HOW FIRST NATIONS YOUTH HEAL FROM ATTEMPTING SUICIDE: A
PHENOMENOLOGICAL STUDY

by

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A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF

MASTER OF ARTS

in

THE FACULTY OF GRADUATE STUDIES
(Department of Educational and Counselling Psychology, and Special Education)

We accept this thesis as conforming to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA

September 14, 2004

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ABSTRACT

The purpose of this study was to conduct an in-depth qualitative exploration of how First Nations youth heal from attempting suicide. In this study there were 12 participants (6 females and 6 males) who were 19 years of age or older. All of the participants experienced either one or more suicide attempts as a youth and at the time of the study had healed from attempting suicide and were comfortable talking about it. Youth was defined as between the ages of 15 to 29. At the time of the participants’ suicide attempts, most of them resided in small communities or reserves on Vancouver Island or Northern, British Columbia.

A phenomenological research method was used to get a rich description of the experience and meaning of how the participants healed from attempting suicide as a youth. Unstructured, one-on-one interviews designed to capture the essence of participants’ stories were conducted. The interviews were audiotaped then transcribed. The transcripts were analyzed for significant statements. The meaning of each significant statement was formulated into meaning units then organized into clusters of themes. Finally, an exhaustive description of the themes and their meaning was conducted. The intention of this study was not to compare females and males but as the analysis unfolded it became apparent that there were important differences. Therefore, separate analysis was conducted for females and males.
The results of the study suggest, what helped the participants heal from attempting suicide as a youth centred on four themes, those being: family, community, self and culture. It appears that the female participants found family and changing the self most helpful and the males found community and working on the self as most helpful for healing. The themes formulated in this study are similar to the First Nations belief of the self as being connected to family, community, culture, spirituality and nature. Also, some of the results from this study confirm other research findings on this topic and contributes additional findings.

This study has implications for counsellors who work with First Nations youth, for suicidal prevention and intervention programs, and for further research.
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ACKNOWLEDGEMENTS

I would like to thank my mother Dorothy for her support, belief in me, and her patients while I pursued my educational goals and was not able to go home for a visit for months at a time.

A special thank you to my good friend Chris who stood by my side and supported me throughout the ups and downs of the last 7 years of my life as a undergraduate student, then a masters student.

I would also like to thank Marlene for her valuable assistance with transcribing. I do not know what I would have done without her speedy typing skills.

To Dr. Rod McCormick, my supervisor, my gratitude for helping me through graduate school and your continuous support. A special thank you for his assistance with making this goal possible for me.

A warm thank you to all of the participants for their time and for kindly sharing their stories with me.

Finally, I am very grateful and appreciative to have had the support and generosity of Pacheedaht First Nations throughout my education. Their help made life as a student a lot easier for me.
CHAPTER I
INTRODUCTION

Suicide is all too common in many First Nations communities, especially among youth. First Nations communities in Canada have been struggling with this problem for a long time and to this date, there have not been many solutions. It is both perplexing and frustrating as First Nations people try to understand why this is still happening to their people, especially the youth, who are important to the future of First Nations culture by keeping it vibrant in Canada.

I am interested in researching how First Nations' youth in British Columbia heal from attempting suicide. My interest in this problem stems from being a First Nations person who has worked with and personally known suicidal First Nations people. I grew up in a small town on the northwest coast of Vancouver Island, and there have been occasions when this small community or one of the surrounding communities grieved the loss of a youth to suicide. There were even more occasions where someone attempted suicide. As a counselling psychology student, I had the opportunity of doing my practicum at a First Nations organization. As a counsellor intern, I provided counselling for First Nations individuals, couples and families as well as facilitated groups. This experience has confirmed for me that suicide is still a serious problem for First Nations people, especially the youth. Almost each client that I had counselled mentioned attempting suicide either in the present or in the past.

Suicide is a problem that has occurred in my private life and in my role as a counsellor. For these reasons, I felt compelled to find out more about First Nations suicide,

1 "Aboriginal" and "First Nations" will be used interchangeably. Statistics Canada (1996) defines Aboriginal as being anyone who is North American Indian, Métis, or Inuit. First Nations are North American Indians who define themselves as a Registered Status/Treaty Indian or Band/First Nation member.
mainly suicide attempts because of it high prevalence, and what can be done to prevent this from happening.

Background of the Problem

The continuously growing literature on First Nations youth suicide is a reminder that this problem still has an important place among mental health concerns (LaFromboise & Graff Low, 1998). Statistics on youth suicide in general is alarming, but when compared to suicide among First Nations youth, the statistics are overwhelming. In 1996, there were a total of 3,941 suicides in Canada, that is almost 11 suicides each day. Between 1970-1996 there has been a steady and significant increase in the suicide rate for 15-19 year olds. Youth between the ages of 20-24 have an even higher suicide rate (Health Canada, 1994; Statistics Canada, 1999). When compared to the general population, depending on the location, the First Nations youth suicide rate has been reported as 2.5 to 6 times higher, especially among males (British Columbia Vital Statistics Agency, 2002; Health Canada, 1994; Royal Commission on Aboriginal Peoples, 1995; Statistics Canada, 1999).

Suicide among First Nations youth is the leading cause of death compared to the Canadian youth population where suicide is the second leading cause of death (Thira, 1999). According to Paproski (1997), the incidence of suicide among First Nations people between the ages of 15-29 is disproportionately high when compared to non-First Nations. First Nations people in British Columbia die by suicide 70% more often than non-First Nations, with the Vancouver Island area having the highest suicide rate among the Status Indian population (British Columbia Vital Statistics Agency, 2002). According to the British Columbia Vital Statistics Agency (2002), there were 96 Status Indian suicides on Vancouver
Island during 1991-1998. This was the highest in the province at 4.3 suicides per 100,000 population.

Although these First Nations suicide statistics are startling, their accurate representation is questionable (Cooper, Corrado, Karlberg & Pelletier Adams, 1992). There is evidence of underreporting First Nations suicide statistics. Garland and Zigler (1993) report that generally statistics on suicide are considered to be low estimates of the true incidences because of the tendency to underreport suicide due to religious, family and financial concerns. Other reasons could possibly include stigmatization and cultural beliefs about suicide. Nevertheless, the suicide rate is of serious concern for First Nations people and communities.

Rationale

Suicide among First Nations youth is an important issue that many First Nations communities and human services professionals continue to be confronted with today (Johnson & Tomren, 1999) as they struggle to find a solution. Research has identified many suicidal risk factors (Cooper, et al., 1992; Gartrell, Jarvis & Derksen, 1993; Kirmayer, Brass & Tait, 2000; McCormick, unpublished paper; Minore, Katt, Kinch & Boone, 1991; Paproski, 1997; Turner, 2001; Wagman Borowsky, Ireland & Resnick, 2001; Wagman Borowksy, Resnick, Ireland & Blum, 1999) but it is still undetermined as to what will prevent First Nations youth from engaging in such self-destructive behaviour. According to Hoover and Paulson (1999), research on suicide intervention and treatment has failed to come up with solutions. Also, traditional Western approaches to suicide treatment have failed and have not reduced suicide. Further research needs to be done on this problem and
especially research on preventative factors among First Nations youth. High suicide rates are especially compelling for First Nations communities to discover prevention efforts that work and for research to switch from focussing on the symptoms of the problem to finding solutions. According to Resnick, Harris and Blum (1993), much of the research on First Nations health has focussed on the problem or pathology and research on First Nations suicide has focussed on identifying risk factors. It is suggested that suicide prevention research should focus on what protects First Nations youth from attempting suicide. Research has found that increasing the number of protective factors was more effective at reducing the probability of attempting suicide than decreasing risk factors (Wagman Borowsky et al., 1999). Therefore, inquiry directed toward understanding what factors contribute to the well-being of First Nations people (LaFromboise & Graff Low, 1998; Resnick et al., 1993) would be beneficial. It is becoming increasingly important to know what the strengths of First Nations people are to understand what can be done to prevent suicide (McCormick, 1998). Such solutions can be derived from individuals who have found ways that helped them heal from attempting suicide and are no longer suicidal (Hoover & Paulson, 1999).

Most of the research on suicide protective factors for First Nations youth has been quantitative (Chandler & Lalonde, 1998; Turner, 2001; Wagman Borowsky et al., 1999). To really understand this problem, research needs to go further than what can be provided by quantitative research methods. There is a need for an in-depth explanation as to the meaning of the protective factors, how they help, and their importance for the First Nations youth. Also, quantitative research approach does not seem suitable for the First Nations culture because of the use of testing instruments, rigid protocols and non-First Nations researchers (Darou, Kurtness & Hum, 2000). For these reasons, there is a need for more qualitative
research. Not only would a qualitative research method seem more appropriate for this cultural group, it will enhance the understanding as to what protects First Nations youth from suicide. Listening to those First Nations people who were suicidal as youths and having them share their story about what helped them heal from attempting suicide may accomplish this. In hindsight, this information could be generated into protective or preventative factors. Similarly, as Polkinghorne (1991) states, the illuminations, understanding and extrapolations derived from qualitative research are useful for the practice of counselling psychology. Therefore, the rationale for this study is to use a qualitative research method that would be more suited for First Nations people and to expand on the research literature on First Nations youth suicide for use in suicide prevention programs and by counselling psychologists.

Purpose of the Study

The purpose of this study is to conduct an in-depth exploration of how First Nations youth heal from attempting suicide.

The objective of this study is to provide information that can possibly be incorporated into suicide intervention and prevention programs, as well as help counselling professionals who work with First Nations youth understand how to prevent suicide attempts or help those heal from attempting suicide. With programs and counselling that foster those healing factors, there is the possibility of reducing suicide behaviors in First Nations youth.

The relevance of this study is that it focusses on a specific cultural group - First Nations people. Knowing more about this culture's own suicidal healing factors allows for greater understanding about what will be useful in the development of suicide prevention programs and counselling interventions. Listening to First Nations peoples' stories about
their own experience with attempting suicide will give them a chance to contribute to the knowledge base of this serious problem. For those counselling psychologists who work within First Nations communities and are aware of suicidal protective factors are better equipped when they have contact with a suicidal youth, because the counsellor will know what needs to be done to help that youth heal.

From what is known thus far about First Nations youth suicide and the gap in the existing research, the research question that will be pursued is how do First Nations youth heal from attempting suicide?

Approach of the Study

The worldview of First Nations people is different from a Western worldview, and a research approach that is similar to the cultural group being study would be beneficial not only for the researcher, but also the cultural group. Darou et al., (2000) mentions that Indigenous psychology is of value to First Nations people and research. Indigenous psychology is defined as “the scientific study of human behaviour that is native, that is not transported from other regions, and that is designed for its people” (Darou et al., 2000, p. 46). The methodological approach used in this study was phenomenological. The main method of data gathering was one-on-one interviews with First Nations people who have attempted suicide as a youth. They were asked to share their experiences with attempting suicide and how they healed from attempting suicide. Major themes were extracted from the data. The major themes and a detailed description of the meaning of the healing factors are provided.

Hoover and Paulson (1999) mention that individual descriptions of healing experiences can illuminate the process of healing. Because a phenomenological approach can
get detailed descriptions and is in keeping with the First Nations tradition of storytelling it is a culturally appropriate method of research. The rich descriptions that are provided allow for further insight into healing from attempting suicide.
CHAPTER II

LITERATURE REVIEW

Literature related to the research question of how First Nations youth heal from attempting suicide is reviewed. This literature review will discuss factors that contribute to the understanding of First Nations suicide in general such as prevalence, risk and protective factors, and suicide preventative and intervention programs. It is followed with what healing means for First Nations people.

Prevalence

Suicidal behaviour among First Nations people is a major problem across Canada. Statistics Canada 1996 Census (1998) reports that 799,010 individuals reported they were North American Indian, Métis or Inuit; this is about 3% of the total Canadian population. Yet, Canadian Aboriginals suffer from one of the highest rates of suicide of any group in the world with a suicide rate that is three times that of Canada’s general population (Kirmayer, 1994). First Nations communities are repeatedly traumatized by the continuation of this problem, which is primarily associated with youth (Kirmayer et al., 2000; LaFromboise & Bigfoot, 1988).

In Northern Ontario, suicide occurs in First Nations communities quite regularly. The Sioux Lookout Zone Hospital, which serves 27 First Nations communities in Northern Ontario, reported 143 attempts and 10 known suicides in 1990 alone. It is suggested that this is only a fraction of the actual suicides that occur (Minore et al., 1991). Kirmayer et al. (2000) report that the Inuit have extremely high rates of suicide ideation and attempts among
adolescent and young adults. In Norway House, a remote Indian reservation in Manitoba, Ross and Davis (1986) examined all successful suicides and parasuicides presented to a hospital and found the overall rate of suicide was 77 per 100,000 population and parasuicide by overdose was epidemic with a rate of 7,722 per 100,000 population.

Studies conducted on suicide in all provinces, territories and states surrounding British Columbia confirmed that the rates of suicide among First Nations people in these areas are significantly high, some as high as 45.2 suicides per 100,000 population (Chandler & Lalonde, 1998; Cooper et al., 1992). Cooper et al. (1992) mention that for towns in British Columbia with a population of fifteen thousand or more, some areas consistently had higher Aboriginal suicide rates whereas in other areas suicide rates were consistently lower. First Nations living within major urban areas have a suicide rate equal to non-First Nations youth (Thira, 1999). But, there is discrepancy with suicide statistics due to underreporting, which will be discussed later. Bagley, Wood and Khumar (as cited in Cooper et al., 1992) found that First Nations rates of suicide increased from south to north of British Columbia and the rates were primarily located in central British Columbia. Areas with low rates of First Nations suicide were mostly northwest or southwest of the province of British Columbia and major urban areas in British Columbia (e.g., Vancouver, Victoria, Prince George) were similar to that of the general population for those areas. The Vancouver Island area has the highest suicide rate among the Status Indian population and was the highest in British Columbia at 4.3 suicides per 100,000 population (British Columbia Vital Statistics Agency, 2002). Aboriginal youth living on a reserve are six times more likely to die by suicide than their non-Aboriginal peers (Thira, 1999).
With 596 Indian bands and 2,284 reserves in Canada there is great cultural diversity among Aboriginal groups (Garland & Zigler, 1993; Kirymayer, 1994), and most Aboriginal communities or reserves have similar problems especially with rapid cultural change, but for some Aboriginal communities, suicide is not as problematic (Kirymayer, 1994). For example, the Cree have suicide rates no higher than the rest of the province of Quebec (Kirymayer et al., 2000). It is not mentioned what protects these communities from suicide but Garland and Zigler (1993) do mention that less traditional tribes have higher suicide rates than do more traditional tribes.

The gender differences among First Nations youth suicide behaviour are similar to suicide behaviour in the general Canadian population. In the general population suicide attempts by females are more common whereas completed suicides by males is more common. In the First Nations population females are more likely to attempt suicide than males, but the rate of death by suicide is higher for First Nations males (Garland & Zigler, 1993). Also, in the general population females use less lethal methods of attempting suicide and males more lethal methods, therefore, more completed suicides. First Nations females use less lethal methods of attempting suicide such as overdoses or cutting wrists, whereas First Nations males use more lethal methods such as gunshot or hanging (Garland & Zigler, 1993; Johnson & Tomren, 1999; Kirymayer, 1994). Even though there are gender differences in suicidal behaviour that reflect the general population, First Nations adolescent females are 7.5 times more likely to commit suicide than their female peers in the general population, and First Nations females between the ages of 20-29 have a suicide rate of 3.6 times the rate for Canadian females. First Nations males between the ages of 10 to 50 have suicide rates higher than the total Canadian male population (Kirymayer, 1994).
It is mentioned that because females are more likely to use mental health or health facilities and that this is where most studies survey suicide attempt records, gender differences for suicide attempts would diminish if research included incarcerated males. Suicide attempts are common among incarcerated males (Garland & Zigler, 1993) and First Nations males make up a high percentage of the prison population (Kirmayer, 1994).

As mentioned earlier, First Nations youth between the ages 15 to 19 are more prone to suicidal behaviour than the general population. Across a lifespan, First Nations youth have the highest risk of suicide (Kirmayer, 1994; Thira, 1999). Suicidal behaviour is reported among First Nations youth and adolescents as young as 10 years of age. But is more common among the ages of 15 to 29 years old where First Nations youth have been reported as 5 to 6 times more likely to die of suicide than their peers in the general Canadian population (Kirmayer, 1994). A study done on Indian reservations located in central Alberta found that of the 229 Indian students from grades 7 through 9 studied (where the age range was 12 to 14), 39% seriously considered suicide and slightly more than 15% had attempted suicide. The rates go up as age increases (Gartrell et al., 1993). For First Nations individuals in British Columbia aged 15 to 24 years, the overall rate was 108.4 suicides per 100,000 (Chandler & Lalonde, 1998; Cooper et al., 1992).

The high rates of suicidal behaviour for First Nations youth between the ages of 15 to 29 is disconcerting because the average age of the Aboriginal population in 1996 was 25.5 and the proportion of young people aged 15 to 24 was also greater among the Aboriginal population (Statistics Canada, 1998). Also, the Aboriginal population continues to grow more rapidly than the total population. In 1996 there were 491 Aboriginal children under the age of five for every 1,000 Aboriginal women of childbearing age. Therefore, within the next
decade there will be a large increase of Aboriginal youth aged 15 to 24 (Statistics Canada, 1998).

When reporting on the statistics for First Nations youth suicide, the validity of the statistics should be scrutinized. Several authors (Chandler & Lalonde, 1998; Cooper et al., 1992; Johnson & Tomren, 1999; LaFromboise & Bigfoot, 1988; Paproski, 1997) state that the underreporting of suicide makes the validity of Aboriginal suicide statistics questionable. Underreporting occurs when the death of an Aboriginal is determined to be either an accident, homicide or undetermined, when it could actually be considered suicide. Cooper et al. (1992) examined a sample of 104 coroner files for Aboriginal deaths between 1987-1989 that had been classified as accidents, homicide or undetermined and also examined a geographically matched sample of non-Aboriginal files. Of the five Aboriginal deaths (two classified as accidental and three as undetermined) the authors rated them as “probable” suicides because not only was the death self-inflicted but there was also corroborating evidence of suicidal intent and/or depression around the time of death.

Similarly, Aboriginal suicides go underreported because of mistakes in labelling the deceased as Aboriginal or non-Aboriginal. Chandler and Lalonde (1998) state that accurate data on whether or not a person is Aboriginal is difficult to collect. When Cooper et al. (1992) examined files of 177 Aboriginal suicides between 1984-1989 and did a geographically matched sample of 177 non-Aboriginal suicides, they found ten of the non-Aboriginal cases were determined to be Aboriginal and one Aboriginal case was determined to be non-Aboriginal. In addition, today there are many children born to parents in interracial relationships and may identify more with one race than the other or appear to look more like
another race. Depending on the child’s upbringing or decision as to which race they identify with this may also need to be taken into consideration when reporting suicides.

Underreporting of First Nations suicide can also occur because of the stigmatization that comes with suicide and cultural or religious beliefs about suicide and, therefore, could be reported as an accident (LaFromboise & Bigfoot, 1988). Also, distortion of First Nations suicide could be a problem because suicide rates vary across tribes. According to Johnson and Tomren (1999) the American Indian population is smaller than the non-Indian population therefore small, localized suicides can have a significant effect on the national comparison rate.

The data reveal the complexity in achieving an accurate picture of the prevalence of First Nations suicide. But, the data still reveals suicide is a problem among First Nations people, especially First Nations youth.

Suicidal Risk Factors

The history of First Nations people and the hardships they endured is well known in Canada. The effects of these hardships continue to exist among First Nations people as a result of them being passed on from one generation to the next. To understand the risk factors that have been found to contribute to suicide among First Nations youth, the history of First Nations people needs to be taken into account. According to Villaneuva (as mentioned in Duran & Duran, 1995), suicidal adolescents and adults hold on to their rapidly eroding tribal traditions and the developmental social structure, which once guided them, but these are no longer relevant or non-existent for some tribes. As a result, having nothing to guide them
there is acceptance of what they believe to be the norm in their culture and may reject their tribal traditions.

Before the arrival of Europeans to North America, First Nations people lived in a society where roles and place in the Tribe were well defined. These roles and functions were supported by family systems and self-governance. Everyone, young and old, felt valued as a member of his or her Tribe (Duran & Duran, 1995).

The role for First Nations males was to protect the Tribe (Duran & Duran, 1995) and provide the Tribe with sustenance through hunting and fishing. The female’s role was to care for the family, prepare food, make clothing and gather berries and herbs. Also, the culture and traditions were thriving with ceremony, songs, dance and storytelling, which were all very important traditions for most Tribes that defined who they are.

Suicide was uncommon for First Nations people and was considered unthinkable. For some Tribes, the belief was that those who did die of suicide would not be given a proper funeral and burial rights, and their spirit would remain in a different realm other than those who died of non-suicidal causes. Suicide was acceptable when it was altruistic suicide due to desperate circumstances such as being terminally ill. The contagious diseases brought by Europeans wiped out many families, which provoked suicide by those individuals left alone (Kirmayer, 1994).

Not only did disease brought over from European explorers wipe out a lot of the First Nations population, there were other severe changes that occurred that would affect First Nations people forever. Also identity quickly eroded as their beliefs in the land, the animals and the elements valued as being important aspects of the self were taken away with the arrival of Europeans to sustain their own living. Kirmayer (1994) states that “Once a hunter-
gatherer society that valued extended family and formed bands and tribes, First Nations were once accustomed to large territories, low population density and relatively unstructured social systems” (pp. 28-29). This came to a drastic end for First Nations people once explorers from Europe colonized North America and took control of the land and the First Nations people. For example, Duran and Duran (1995) reports that “for over five hundred years Europeans have attempted to subjugate, exterminate, assimilate and oppress Native American people. The effects of this subjugation and extermination have been devastating both physically and psychologically” (p. 27).

Beginning in the late 1800s, the Canadian government devised and implemented policies that were made to appear as if they were for the purpose of educating First Nations children. When, in fact, they were implemented to systematically destroy First Nation families and culture and assimilate them into Western society (Duran & Duran, 1995).

Residential schools were the government’s means of destroying First Nations families. Children were forced to attend these boarding schools where they were stripped of their culture by not being allowed to speak their language or engage in their cultural activities. Instead they were taught Christianity and that any religious beliefs of their Tribe were the devil. These practices were never questioned and were successful at destroying First Nations people and culture (Duran & Duran, 1995). In addition to culture, residential schools were also detrimental for First Nations people because these schools deprived children of family bonds and cultural identity and exposed them to physical and sexual abuse. There is evidence of high rates of suicide attempts among residential school students (Kirmayer, 1994).
When a group of people have experienced genocide, there are psychological consequences. There is a loss of power and despair because of genocide. The consciousness reacts by internalizing the power of the oppressor. The self-worth of the individual and/or group turns to self-hatred, which can become internalized and can result in suicide as has happened to First Nations people (Duran & Duran, 1995). According to Duran and Duran (1995), “Many of the problems facing Native Americans today, such as suicide, have become part of the Native American heritage due to the long decades of forced assimilation and genocidal practices implemented by the federal government” (p. 35).

Much of the literature on First Nations suicide agrees that loss of culture is one risk factor that seems to have an effect on the occurrence of First Nations suicide (Chandler & Lalonde, 1998; Duran & Duran, 1995; Minore, et al., 1991; Kirmayer et al., 2000). Loss of culture includes language, ceremonies, traditions, values and beliefs. In other words, they lose their identity. Communities that are not practicing their Aboriginal culture have high rates of suicide (Chandler & Lalonde, 1998; Duran & Duran, 1995; Minore, et al., 1991; Kirmayer et al., 2000). There is a lack of cultural awareness and involvement among youth that makes them susceptible to suicide. Also, according to LaFromboise and Bigfoot (1988) high rates of suicide among American Indian adolescents are a major symptom of cultural value clashes. Some American Indians, as well as First Nations, youth feel trapped between two different worlds and isolated because they cannot fit into either mainstream society or American Indian society. For example, as reported by a Native youth in northern Ontario, suicide can result in feeling torn between two cultures and not being able to fit into either. Often these cultural idiosyncrasies can contribute to alienation and depression (LaFromboise & Bigfoot, 1988). More will be said about psychological factors later.
The impact of loss of culture for First Nations youth today puts youth at risk for suicide because they lose a sense of identity. It is reported that some suicidal Aboriginal adolescents say they feel a lack of identity and sense of self (Minore et al., 1991). Chandler and Lalonde (1998) studied the relationship between the risk of suicide in First Nations youth and cultural continuity. Chandler and Lalonde (1998) describe cultural continuity as “the ways in which these young persons undertake to construct and defend a sense of identity that allows them to survive as continuous or numerically identical persons despite often dramatic individual and cultural change” (p. 213).

Chandler and Lalonde (1998), also mentioned in Chandler, Lalonde, Sokol and Hallett (2003), found various markers of cultural continuity missing from First Nations communities with high youth suicidal rates. These markers are: land claims, self-government, education services on reservation, police and fire services on reservation, health services on reservation, and cultural services. When summed across these cultural markers it was found that suicide rates ranged from a high of 137.5 for communities with no markers to zero for communities will all six markers present.

Aside from the affects of the colonialism and residential schools on First Nations people, there are many other risk factors that contribute to suicide for First Nations. Hoover and Paulson (1999) mention that risk factors can also include psychiatric disorders, personality traits, family history, and psychosocial stressors and events to mention a few.

There are environmental factors that can contribute to the risk of suicide among First Nations (Johnson & Tomren, 1999; Kirmayer, 1994; LaFromboise & Graff Low, 1998). The environment has always had an important role for First Nations people. The self and personhood has implications when there is an assault on the environment. For First Nations
peoples the land, the animals, and the elements are all in transaction with the self and in some sense constitute aspects of the self. Damage to the land, relocations, and restricted mobility is a direct assault on the self. There is a loss of self-esteem and self-efficacy that has to do with living on and through the land (Kirmayer, 1994).

Reserve land that the government imposed on First Nations people is an example of how the environment affected them. First Nations were restricted to small, remote pieces of land that often were not feasible for living off of as resources were limited. Many First Nations people still live on reserves and some are located in such remote areas that they are only accessible by plane. Some First Nations people living on a reserve experience poor living conditions, poverty, high unemployment, dependence on welfare, addictions and limited social or human resources. According to Kirmayer (1994), suicide rates have been found to strongly correlate with the percentage of population below the poverty level among Native Americans in the United States and among Native Canadians for example, in Alberta. In the general population, suicide attempts related to unemployment are common for both men and women. Rates of unemployment are much higher among Aboriginal peoples than in the general population. Although it is explained that because poverty and unemployment are the status quo for the Aboriginal population, it is seldom reported as a problem in suicides and no more a problem for the victim than it is for the rest of the community (Kirmayer, 1994). This may not mean that unemployment is not a risk factor in Aboriginal suicide though. Some people experience a great sense of loss when a job that they feel gave them their sense of identity is suddenly taken away from them.

First Nations people also experience frequent relocation (Kirmayer, 1994; LaFromboise & Graff Low, 1998). For those First Nations who decide to move away from
their reserves into urban areas often the transition is not easy. LaFromboise and Bigfoot (1988) mention that American Indians have to deal with being stuck between two cultures and are often reminded of the negative stereotypes and racism associated with being American Indian. This may also be the case for First Nations who relocate to urban areas.

Another environmental factor according to Kirmayer (1994) that contributes to the risk of suicide among Aboriginals is incarceration. As mentioned earlier, First Nations have one of the highest rates of prison population. Due to isolation and seclusion because of being away from their family and community puts First Nations criminals who are in custody at risk for suicide. Even getting in trouble with the law can contribute to both immediate and long-term suicide risk as First Nations fear life behind prison walls or returning to prison. For first time offenders, being sent to prison may bring with it shame and guilt for the crime. Also, there is the rejection from the family and community for some First Nations who end up incarcerated.

Developmental factors that First Nations youth experience related to loss, separation, neglect, emotional deprivation and abuse could lead to suicide (Kirmayer, 1994). First Nations populations experience a high frequency of childhood separation that dates back to the early 1800s with residential schools. The children of residential schools lost the experience of being raised by parents and lost good parenting role models. This has a negative effect on their skills as a parent when they have children. Poor parenting has a serious impact on First Nations youth and may be another factor that contributes to suicidal behaviour.

Within First Nations communities family breakdown is common. Many First Nations children are raised in a single parent home (Kirmayer, 1994) or by extended family. Being
raised in a single parent home does not predict suicide risk unless there is sufficient support
from a parent, extended family, relatives, elders and members of the community (Kirmayer,
1994). Some youth end up in and out of foster homes until they reach adulthood and these
homes are usually non-First Nations homes. This experience could also put them at risk for
suicide (Johnson & Tomren, 1999) because they may feel unloved or abandoned by their
family. A recent family history of suicide is also associated with youth suicide (Resnick,
Bearman, Blum, Bauman, Harris, Jones, Tabor, Beuhring, Sieving, Shew, Ireland, Bearinger
& Udry, 1997). The youth might experience intense grief or guilt over the loss of a loved one
due to suicide. They would blame themselves for the death. Also, a desire to be with the
deceased, especially if is was a significant relationship, may lead to the youth attempting
suicide so he or she could be reunited with the deceased. Youth who witness suicide by
someone in their family may see this behaviour as an appropriate way out of their own
problems and model suicidal behaviour. Therefore, the dynamics of the family, or lack
thereof, has serious consequences for youth.

An interpersonal factor such as a relationship with family members, friends,
boyfriends or girlfriends for First Nations youth has an impact on suicidal risk. Kirmayer
(1994) mentions that empirical evidence indicates that the quality of the individual’s social
network is a strong predictor for the risk of suicide attempts. Also, interpersonal conflicts
with family, marital discord, breakup from a significant relationship, or loss of personal
resources are common precipitants of youth suicide. Kirmayer (1994) suggests that multiple
losses of family, tradition and community lead youth to intense dependence on a love
relationship. This intensity increases the vulnerability for interpersonal conflict, physical
abuse and catastrophic reaction when the relationship shows signs of falling apart. Conflicts
with friends or difficulty fitting in among peers and bullying are other interpersonal risk factors. Inadequate parenting practices, feelings of being unloved or unwanted by parents, and little or no communication with parents were reported as distressing for many adolescents in the Minore et al. (1991) study. Poor modelling or lack of appropriate role models were other interpersonal problems that could put Aboriginal youth at risk for suicidal behaviour (Gartrell, et al., 1993; Minore et al., 1991). For troubled youth, the lack of support within their own families may be made worse by the fact that often there is no one else in a position to help them, and there are not enough outlets or positive helpers (Minore et al., 1991). These types of interpersonal and relationship problems can contribute to youth suicidal behaviour (Cooper et al., 1992; Minore et al., 1991; Ross & Davis, 1986).

As mentioned earlier, there were psychological consequences from the impact of colonialism on First Nations people and these may have been passed down from generation to generation. The psychological problems experienced by today’s First Nations youth pose as a suicidal risk factor (Cooper et al., 1992; Gartrell, et al., 1993; Minore et al., 1991). LaFromboise and Graff Low (1998) mention that little research has focused on the psychological development of Indian children and adolescents, but some studies have estimated the prevalence of psychological disorders among them. Psychological problems mentioned are developmental disabilities, depression, anxiety, alcohol and substance abuse, and personality and behaviour problems. Gartrell et al. (1993) found among the 229 grades seven to nine adolescents in their study, suicide ideations and attempts were significantly related to low psychological well-being. Minore et al. (1991) mention that Aboriginal adolescents from the Nishnawbe-Aski Nation in Ontario reported feelings of hopelessness and anxiety about their future. This is succinctly stated by a young lady with whom Minore
et al. (1991) spoke, “Some of the reasons that we hear about why suicides happen are that a lot of our people are feeling there’s not hope for the future” (p.11).

In a study of 77 Canadian adolescent inpatients, 50 Caucasians and 27 Aboriginal, between the ages of 12 and 18 who attempted suicide, Enns, Inayatulla, Cox and Cheyne (1997) found that hopelessness was not predictive of suicide intent for Aboriginal adolescents and that the severity of depression was predictive. The results for the Caucasian adolescents were contrary to the Aboriginal group. The problem with epidemiological studies that involve Aboriginal people is the use of culturally biased instruments (LaFromboise & Graff Low, 1998). The authors do not mention if the instruments used in this study (Beck Depression Inventory, Beck Anxiety Inventory, Hopelessness Scale, and Suicide Intent Scale) were suitable for their Aboriginal subjects.

Although the psychiatric perspective of suicide indicates psychiatric disorders such as major depression are strongly associated with high suicide risk, Kirmayer (1994) states that:

An argument can be made, however, that given the widespread of social problems faced by Aboriginal peoples in Canada, viewing suicide strictly as the outcome of a psychiatric disorder actually aggravates the situation. Psychiatric explanations are stigmatizing and so add to the feelings of estrangement, devaluation, and powerlessness that contribute to suicide attempts. A psychiatric approach directs attention on the pathological individual rather than to the basic social problems that demand remediation. Labeling whole communities as ‘sick’ is a metaphor that may contribute to pervasive demoralization. From this perspective, it would be best to find a means to address hopelessness without labeling it as an illness at either the individual or community levels (p.40).

Not only is drug and alcohol abuse another problem for many First Nations people, even for youth, it contributes to an increase risk of suicide (Westefeld, Range, Rogers, Maples, Bromly & Alcorn, 2000). Alcohol intoxication has been noted to be a major factor contributing to suicide in Aboriginal people (Kirmayer, 1994; Duran & Duran, 1995). Drug
and alcohol abuse is common and highly present in many Aboriginal suicides (Cooper et al., 1992; Gartrell et al., 1993; Kirmayer et al., 2000). One study done in British Columbia (as cited in the Royal Commission on Aboriginal Peoples, 1995) found that 74% of Aboriginal people who completed suicide were intoxicated, compared to the 36% of a matched sample of non-Aboriginal suicides. Cooper et al. (1992) report that approximately 60% of British Columbian Aboriginals who committed suicide were acutely intoxicated at the time of the act and almost 20% had a blood alcohol level above 0.20. Over half of those who were not acutely intoxicated at the time of suicide had a personal history of alcohol abuse. Both Cooper et al. (1992) and Ross and Davis (1986) state that some of these suicides probably would not have occurred if the victim had not been intoxicated. The problem with these data is determining if substance abuse leads directly to suicide or are substances abused to mask a larger problem in one's life, which leads to suicide.

Physical and sexual abuse is common in First Nations families and communities. Suicidal behaviour is seen in youth with a history of being sexually and physically abused (Cooper et al., 1992; Kirmayer et al., 2000; Paproski, 1997; Minore et al., 1991). In Paproski’s (1997) study of five First Nations women from British Columbia sharing their experience with suicide as an adolescent, four of these women experienced sexual and/or physical abuse from family members or in foster homes. Although it is difficult to generalize these results, this small study indicates abuse is possibly a factor in contributing to suicidal behaviour. Kirmayer et al. (2000) reports that their study on Aboriginal youth from Inuit communities found a history of physical abuse to be a factor in adolescent suicide attempts and ideations. Often the victim of abuse feels alone and trapped when it comes to exposing the abuse because of geographic isolation and extended family relations. This feeling of
being trapped contributes to suicide. Without any support available, suicide risk is high
(Kirmayer, 1994).

**Suicidal Protective Factors**

Certain cultures have low suicide rates such as Latin, African-American and Asian
(Westefeld et al., 2000). The reason being is that these cultures are thriving and their
traditions are constantly being practiced. Duran and Duran (1995) mentions that suicide rates
are the lowest for Pueblos, tribes and individual Native American families in communities
for which their traditions are workable and viable.

Determining what the protective factors are for First Nations youth who live in
communities with low suicide rates has implications for those communities with high First
Nations youth suicide. Forman and Kalafat (1998) state that investigators are beginning to
advocate an emphasis on more research on protective and resiliency factors, especially in
environments where it is difficult to reduce exposure to risk factors. For many First Nations
youth living in rural and remote areas where suicide is usually high reducing exposure to risk
factors are difficult. Therefore, enhancing protective factors is critical.

As mentioned earlier, the loss of culture and traditions can be a suicidal risk factor for
First Nations people. Therefore, First Nations youth that come from tribes that actively
practice their cultural traditions are less likely to experience unhealthy behaviour such as
suicide than those youth whose tribes are not traditional or are acculturated (Duran & Duran,
1995; Johnson & Tomren, 1999; LaFromboise & Graff Low, 1998). For example, The
Alkalai Lake Band in British Columbia, which suffered from years of alcoholism among its
members, was able to decrease its alcohol rate from 95 percent to 5 percent by no longer
tolerating alcoholism in the community and revitalizing their traditional culture (as mentioned in Duran & Duran, 1995).

According to Chandler (2000), First Nations adolescents experience of being a self during times of change are influenced by either historical or cultural circumstances. Chandler and Lalonde (1998) examined self-continuity and its role as a protective factor against suicide in First Nations communities. They argued that risk for suicide is heightened when identity is undermined by radical personal and cultural change. Therefore, they lose future commitments that are necessary for their well-being. This period of increased risk is even more acute when communities lack a cultural continuity that would otherwise support a young person to develop self-continuity-warranting practices. Chandler and Lalonde (1998), also mentioned in Chandler et al. (2003), found that when a community has in place some or all of the markers of cultural continuity, which include land claims, self-government, education services on reservation, police and fire services on reservation, health services on reservation, and cultural services they serve as protective factors and the suicide rate is low. A community with self-government appears to be the largest protective marker with an estimated 102.8 fewer suicides per 100,000 youth (Chandler & Lalonde, 1998). According to Hassenfeld (as mentioned in Poonwassie & Charter, 2001), “A key aspect in decolonization is empowerment – a process that facilitates access to personal, organizational and community resources in order to have control of one’s life” (p.69).

The value of Chandler and Lalonde’s study (1998) is that it gives another perspective into suicide protective factors and what needs to be done in First Nations communities as a whole in order to prevent suicide. The drawback of this research is that it used documents from various government agencies to determine the community protective factors. This study
would have also benefited from the community’s insight as well. Also, Chandler and Lalonde (1998) do not mention what these markers mean to the youth that makes them important suicide protection factors. It may be that a sense of being in control and having a thriving First Nations culture in the community protects youth from suicide.

One cultural belief in First Nations culture is that of the importance of family, extended family and community in raising the young. According to LaFromboise and Graff Low (1998):

> Indian people live in relational networks that serve to support and nurture strong bonds of mutual assistance and affection. Many tribes still engage in a traditional system of collective interdependence, with family members responsible not only to one another but also to the clan and tribe to which they belong…When problems arise among Indian youth, they become problems of the community as well. The family, kin, and friends join together to observe the youth’s behavior, draw him or her out of isolation, and integrate that person back into the activities of the group (p. 118).

At one time, family and extended family was the core of First Nations communities. Protecting First Nations youth from harm, especially from suicide would have to involve the family, extended family and community. In the Royal Commission of Aboriginal Peoples (1995), it is stated that Aboriginal families must become the object of long-term community-based efforts to reinforce parenting skills and stop the violence and abusive behaviour. Aboriginal people must return to the traditional family values of respect for women and children, mutual responsibility and the general belief of sharing and caring.

Minore et al. (1991) used a focus group approach with the Nishnawbe-Aski Nation to determine what they perceive as the causes of adolescent suicide and how to respond to it using an internal/external locus of control model. Similar to Chandler and Lalonde (1998), Minore et al. (1991) found that community played a role in lessening suicide. To find a
solution to overcome internal and external causes of suicide they must look within their community strengths upon which coping strategies can be built. These strengths are religio-cultural traditions and existing supportive relationships. A problem with this research is that they received plenty of objective opinions from the community at large, but it does not mention if anyone who is a survivor of suicidal behaviour was involved.

Family composition, whether it is a two parents or single parent family, does not seem to have an effect on suicide among First Nations youth. Resnick et al., (1993) did a study on protective factors against the quietly disturbed and acting out behaviours (which included suicidal behaviour) of 36,000 grade 7 to 12 students. There was no mention of the ethnic make up of the sample. It was found that family promoted well-being among young people without the form or composition specified as long as there was at least one caring, competent adult in a loving, nurturing relationship. Single parent homes are common among First Nations families and mainly headed by women. This does not predict suicide risk unless there is a sufficient support from parents, extended family, relatives, elders or members of the community (Kirmayer, 1994).

Two studies used a national adolescent health survey to find protective factors associated with suicidal attempts among First Nations male and female youth (Turner, 2001; Wagman Borowsky, et al., 1999). A National American Indian Health Survey (Wagman Borowsky et al., 1999) found that for both male and female respondents, discussing problems with friends or family, having emotional health, and connectedness to family were protective factors against suicide attempts. Turner’s (2001) study on a Canadian sample found similar protective factors using an Adolescent Health survey. The sample included both First Nations
and non-First Nations adolescents. Protective factors for both groups were parental support and self-appraisal.

Arato-Bollivar (2004) did a critical incidence study on what helped suicidal Aboriginal youth survive a 'low' point in their life when they had extreme suicidal thoughts, behaviour and/or actions. Of the 14 incidences, responsibility to others, connection to family, professional support, non-family/non-professional support, and change in thinking had the highest number of incidences. These survival factors have important implications for community, families and helpers in knowing what will protect youth through a difficult time in their life as well as teaching youth coping skills. What is interesting though about this study is that culture, spirituality and connection to nature had a lower number of incidences. There is evidence that some aspects of First Nations culture are important suicide protective factors. In Paproski's (1997) study, five First Nations women described some common themes about how they overcame their suicidal behaviour when they were youths. Those themes were related to the experience of ancestry and cultural connections, spiritual connections and connections with elders. Unfortunately, because of the small sample size, generalization of the results is difficult, which Proposki (1997) mentions.

Cooper et al. (1992) mention that traditional practices such as, sweat lodges, healing circles, performing songs and dances, and traditional fishing and hunting practices may foster and nurture a positive self-image for First Nations youth. It could also be argued that not only would traditional practices such as these enhance self-image they would also enhance cultural identity. With a positive self-image and cultural identification both of these may contribute to suicidal protection.
Teachings of the Medicine Wheel can be a beneficial, traditional protective factor for First Nations youth. According to Montgomery, Miville, Winterowd, Jeffries and Baysden (2000) traditional means “multiple interconnections of emotional, physical, intellectual, and spiritual identity that combine to define expectations for the Indian way” (p.388). The Medicine Wheel identifies four important elements for balance in life. The elements are spiritual, mental, physical and emotional and when maintained help restore balance and harmony to life (Duran & Duran, 1995; McCormick, 1995; Poonwassie & Charter, 2000). Good health is reflected when all of these elements are in balance and when they are not in balance health suffers in all areas, sometimes resulting in suicide (Duran & Duran, 1995; Poonwassie & Charter, 2000). Continuous check-in by First Nations youth of the balance in their life could help them identify what elements they need to enhance for their well-being and could identify what they need to do to restore balance.

Most of the protective factors mentioned thus far should not to be thought of as separate of one another. For these protective factors to be effective at protecting First Nations youth from suicide they need to be interconnected.

Suicide Prevention and Intervention Programs

Most of the literature examined on suicide prevention and intervention programs agrees that most of the programs available have not been successful at reducing youth suicide and have failed many (Garland & Zigler, 1993; Hoover & Paulson, 1999; Kirmayer, 1994; LaFromboise & Bigfoot, 1988). Kirmayer (1994) mentions that there is little evidence that the suicide interventions available have been valuable and useful at reducing suicide and that some suicide preventions create more harm than they do good, i.e. school-based
interventions. Also, there are not many published evaluation studies and most of them are poorly designed, such that there is no control group (Garland & Zigler, 1993). These programs have been criticised as minimally effecting in providing knowledge and ineffective in changing attitudes. One of the reasons why suicide prevention and intervention programs have not worked has been identified. Many of the intervention efforts have not benefited from research findings because of inadequate communications between the researcher and intervention developers (Garland & Zigler, 1993). For example, curriculum-based suicide prevention programs have not demonstrated being effective, efficient and may, in fact, contain potentially harmful components. According to Garland and Zigler (1993) suicide can force program planners and policy makers to act hastily, in the absence of empirically derived knowledge on which to base social actions.

The purpose of suicide prevention and intervention programs that are curriculum-based or education programs in schools that are directed toward students, their parents and educators is to destigmatize suicide and encourage students who are suicidal to identify themselves and get help. There seems to be several problems with this type of program. One has to question whether this would work in a school setting, especially if it is a small school in a small community. Would destigmatizing suicide usually make it easier for a student to identify himself or herself and seek help? Who would they identify themselves to? Just the fear alone of having to identify themselves could prevent the student from seeking help. Some students might seek help outside of the school to prevent having to identifying themselves to school staff or their peers, or sometimes circumstances prevent them from going to parents for help.
Other problems with curriculum-based suicide prevention and intervention programs identified by Garland and Zigler (1993) are that many curriculum-based programs were not developed on current empirical knowledge of the risk factors of adolescent suicide. Also, the incidence of suicide sometimes involves unnecessary exaggerations to increase awareness and concern. For some students exaggeration of suicide may not increase concern but appear glamorous and a way to seek attention or recognition. The suicide of Kirk Cobain is a good example of glamourized suicide. Another problem with school-based suicide prevention programs is that it may not reach their target population, because those most at risk are likely to be absent from school often because of their suicidal behaviour. A more practical suicide prevention and intervention program for schools is one that emphasizes skill building to manage a variety of health issues as part of the educational curriculum. This would enhance students’ coping skills, distressful emotions, problems solving and interpersonal communications skills (Kirmayer, 1994). Garland and Zigler (1993) suggest the implementation of integrated primary prevention programs that focusses on the risk factors.

Similarly, Johnson and Tomren (1999) suggest that suicide intervention must take an active, critical approach. Action guidelines must decrease impacts among factors associated with suicide rather than simply reacting to the suicide event itself. This approach anticipates a likelihood that suicidal behavior will occur within a given population, for example First Nations people, impacted by selected circumstances. These specific risk factors can be suicidal predictors. Determining what these predictors are can be accomplished by using a “psychological autopsy” on people deceased due to suicide. This would retrace life events of the person prior to the suicide. The psychological autopsy could consist of a team of psychologists, psychiatrists, social workers and nurse-clinicians headed by a person from the
same tribe as the suicide victim. This multidisciplinary team approach would be used to identify areas where intervention could have been introduced. The drawback to this approach is that it focuses on after the fact that the suicide happened and for some First Nations communities having a team of experts involved would be uncomfortable for the family and the community.

The problem with Garland and Zigler (1993) and Johnson and Tomren (1999) suggestions for suicide intervention and prevention programs to focus on reducing risk factors is that it has identified that reducing risk factors does not prevent suicide and that increasing protective factors does (Wagman Borowsky, et al., 1999). Also, prevention programs must identify First Nations peoples' strengths to avoid contributing to pervasive demoralization (Johnson & Tomren, 1999; Kirmayer, 1994).

Outside of the school institution, suicide prevention and intervention programs could focus on other institutions such as the family and health workers. Family support programs could empower families by helping them improve their ability to cope with debilitating life stresses. This type of program works on improving relationships, strengthening support networks and improving the quality of institutions that support youth (Garland & Zigler, 1993). Planned intervention must reconnect the suicidal youth with a human resource that fits his or her particular need. Often members of the extended family, peers or teachers need to get involved. This network needs to reach out and reenter the life of the suicidal youth (Johnson & Tomren, 1999). Education on suicide prevention for paediatricians, heath workers such as nurses, and mental health care workers could help them identify suicidal warnings and provide community mental health resources. According to Garland and Zigler (1993) successful therapeutic intervention with suicide attempters is certainly an important
prevention strategy but youth are non-compliant in treatment. Of these intervention programs, the only one that seems to be beneficial is improving family support programs because it does not focus on the problem, but rather the solution.

Suicide intervention and prevention programs developed for the general population may not be useful for different cultural groups. Wagman Borowsky, et al. (2001) mention that, “a better understanding of factors that predict and protect suicidal behaviours among racial/ethnic groups of adolescents is needed to identify modifiable factors and develop culturally responsive prevention and intervention strategies” (p. 485). One of the recommendations for suicide prevention and intervention is the reestablishment of Aboriginal culture and traditions within communities (Chandler & Lalonde, 1998; Cooper et al., 1992; Kirmayer, et al., 2000; Minore, et al., 1991; Royal Commission on Aboriginal Peoples, 1995). LaFromboise and Graff Low (1998) mention that there is empirical support for the importance having a cultural component in intervention. Psychotherapy and other mental health interventions focus on one particular cultural concept with specific values, and these approaches may not fit well with traditional Aboriginal values or practices of emotional healing. Family and community approaches may be more appropriate for Aboriginal cultures especially if they incorporate some notion of interconnectedness (Kirmayer, 1994). Kirmayer (1994) argues that community interventions that include culture and customs of the band or community are important, but “The challenge then is to encourage and support local initiative that build on traditional values to provide renewed solidarity and integration that reaches alienated youth” (p. 36).

Prevention and intervention programs that help First Nations youth reconnect with their culture can be accomplished by getting them involved in cultural activities such as
dancing and singing. Because there seems to be a lack of First Nations role models for youth these activities can be taught by other youth or elders. Role modeling is a powerful means of teaching and of helping youth incorporate traditional values through passing on traditional knowledge. Youth experience appropriate behaviours that are enacted by positive role models (Poonwassie & Charter, 2001). Johnson and Tomren (1999) mention role modeling has compelled American Indian groups to develop ways to reach Indian youth. One example is “Project Dream” a traditional Indian music group started by youth who were former drug and alcohol abusers. Forming musical and dance groups such as “Project Dream” provides cultural reconnections which are important in reducing self-destructive behaviour, and this can also utilize the elders once again as role models for youth at risk. In urban areas such as Los Angeles and Orange counties, those American Indian youth involved in the dance and music groups diverted from gangs and other forms of self-destructive behaviour as a result of the cultural reconnections. If at-risk Indian youth can be reached through this type of intervention, reconnected with their culture through traditional song and dance, and viewing tribal elders as role models, the suicide rate among American Indian youth can be significantly reduced (Johnson & Tomren, 1999). There is a possibility that this type of program would provide a false hope for youth. Johnson and Tomren (1999) do not give any support by empirical evidence that this type of intervention can significantly reduce suicide.

A suicide prevention and intervention program that could be useful for First Nations suicide involves a transactional, cognitive-phenomenological approach to psychological stress and coping. According to LaFromboise and Bigfoot (1988), most prevention and treatment programs for Aboriginal adolescents focus on “end-stage” behaviours. The transactional, cognitive-phenomenological approach provides a framework with which to
analyze personal, situational and cultural issues that influence the nature of Aboriginal suicide. This model emphasizes the dynamic relationship between a person and the environment. The at-risk person considers what is at stake (i.e., values, goals, beliefs, commitment) and what coping resources are available to manage the demands of the situation. When the issue at stake is valuable to the at-risk person and there are inadequate coping resources to help the person manage the demands of the situation, psychological stress is experienced. Unfortunately, this type of program does not help the adolescent understand explicitly the dynamics of coping with stress or guide them in acquiring skills effective for living. Thus, the person side of the person environment transaction has received less attention (LaFromboise & Bigfoot, 1988).

LaFromboise & Bigfoot (1988) suggest an addition to this approach is to focus on the thoughts, images and inner conversations that Aboriginals use to counteract setbacks and hardships. These cognitions, elicited from Aboriginals who cope effectively, can be incorporated into a self-control cognitive coping suicide prevention program to help Aboriginal youth cultivate cognitive coping strategies. A distinctive feature of this transactional model of coping is the newly created level of thought during the interaction in which the person and environmental elements are joined together to form a new relational meaning. As difficult thoughts and feelings are reframed into more understandable and controllable events the relationship between the First Nations youth and the environment causing distress is altered. As First Nations youth understand the transactional process of coping, they become more adept at regulating their own behaviour. They begin to use a range of coping options that they have not considered previously. As they feel more effective, they become less interested in self-destructive forms of coping and more involved in exercising
more effective means of coping. LaFromboise and Bigfoot (1988) present an example of how Western psychology can be used in suicide prevention and intervention programs for First Nations youth. In 1988, when this article was written, the success of this cognitive-behavioral suicide prevention program was yet to be determined (LaFromboise & Bigfoot, 1988).

LaFromboise and Graff Low (1998) and Heilbron and Guttman (2000) report that social cognitive interventions have been considered less culturally biased than other theoretical approaches because they recognize the impact of culture on personal and environmental variables and allow each culture to define its own appropriate behaviors or targets for intervention. Social cognitive interventions have been successful in parenting, assertiveness and substance abuse. The theory behind cognitive therapy is that:

...people respond to life events through a combination of cognitive, affective, motivational, and behavioral responses...The cognitive system deals with the way that individuals perceive, interpret, and assign meaning to events...Sometimes responses are maladaptive because of misperception, misinterpretations, or dysfunctional, idiosyncratic interpretations of situations. (Corsini & Wedding, 2000, p.241).

Psychological problems can be learned within one’s social surroundings and maintained through cognitive reinforcement. Beliefs that are irrational by the standards of the dominant culture may be perfectly reasonable for First Nations culture. The cognitive process involved in suicidal individuals is that there is a high degree of hopelessness and there is difficulty in problem solving (Corsini & Wedding, 2000). The types of suicidal interventions that involve cognitive therapy will provide First Nations youth with a repertoire of coping options (LaFromboise & Graff Low, 1998). According to Duran and Duran, (1995):
The Native American worldview is a systemic approach to being in a world that can be best categorized as process thinking, as opposed to the content thinking found in the Western Worldview. Process thinking is best described as a more action and “eventing” approach to life versus a world of object relations (p. 15).

Suicide intervention and prevention programs that are based on systems theory have also been recommended for First Nations youth (LaFromboise & Graff-Low, 1998). System theory integrates the strengths inherent in First Nations extended family networking. Systems theory assumes that the individual and the environment have continuous reciprocal interactions, that a client is one portion of a dynamic and interrelated whole and includes transactional analysis, family therapy and group therapy interventions. Most helpful therapeutic interventions are those that enhance an individuals’ interaction with others or with the environment, therefore, ensuring lasting change outside of the therapeutic relationship. This approach takes advantage of the support from extended family while family members become aware of their own maladaptive patterns that may contribute to an individual’s dysfunction. Drawing a genogram, a portrait of the family, or telling a story about their family could get out important information about the family function. Also, getting the family involved in therapy by telling their own story is recommended (LaFromboise & Graff-Low, 1998).

Group therapy would be a suitable suicide intervention program for First Nations youth because it resembles a talking circle (LaFromboise & Graff-Low, 1998). Talking circles can bring together individuals who are going through similar problems, therefore, do not feel alone. In the talking circle, there are specific guidelines as to who gets to share or talk and usually begins and ends in a traditional manner i.e., smudge or prayer, and connects First Nations youth not only with their peers but also their culture. Heilbron and Guttman
(2000) did a study on the group counselling process that integrated the Aboriginal healing practice of a healing circle (involved traditional ceremony and beliefs) with conventional cognitive therapy. The inclusion of traditional ceremony and beliefs into group therapy for First Nations women appeared to increase therapeutic effectiveness. Unfortunately, generalization on this study is difficult because the group consisted of only three First Nations women and two non-Aboriginal women.

A traditional model of suicide intervention recommended by Duran and Duran (1995) combines Western and First Nations tradition that creates change for the individual. The component that is critical to this type of model is a traditional component and the traditional Native American psychology as its core metaphor. This traditional model of suicide intervention would also include traditional counsellors and traditional medicine people and ceremony and sweats as part of its treatment and prevention strategy. A suicide prevention model that encompasses the family and community is also important. Because this model validates traditional values, it is possible that it would be successful at preventing suicide (Duran & Duran, 1995). Duran and Duran (1995) mentions a suicidal client of his who did not have a spiritual life or practice that made sense to him, but when introduced to a sweat ceremony, the client had a completely changed attitude toward committing suicide. Therefore, reconnecting with one’s First Nations culture from which First Nations people often draw their strength is important (Johnson & Tomren, 1999).

Healing for First Nations People

Healing is usually thought of as becoming healthy again after a physical injury. There are certain activities people engage in to heal their physical injury such as visit the doctor, get
an operation, take medication, physiotherapy, bandage and ointment etc. Similarly, healing can also be applied to becoming healthy again after a psychological injury due to trauma, addictions, abuse or even suicidal behaviour. Healing can be thought of as the process one undergoes when wounded to become healthy again, hence the term “healing journey.” The healing journey never really ends but the wound does not affect the person life as much as it once did. Psychological healing is not as easy as physical healing. Psychological healing is different for different people and even cultures. Western medicine can prescribe medication and Western psychology can apply counselling but this form of healing is not for every person or culture. To establish how certain cultures, such as First Nations people, heal from their psychological wounds, it is best to find out what has worked for individuals who are from that culture.

What does healing mean for First Nations people? According to McCormick, (1995 & 2000) many of the mental health problems that Aboriginal people experience are because of disconnection to their culture and values. Connection to Aboriginal culture and values involves being connected to all of creation, which includes culture, family, community, spirituality and nature. An important part of healing is to reconnect with these aspects of creation because it would provide meaning of what it is to be Aboriginal and their values. When an Aboriginal person is disconnected from their values he or she is disconnected from being Aboriginal. This disconnection has resulted in many mental health problems for First Nations people. As mentioned earlier, historically, First Nations people have been wounded as a result of colonization. Unfortunately, those wounds remain unhealed today as many First Nations people have addictions problems, are incarcerated, experience abuse of all types, and are stricken with poverty and suicide.
Several studies have been done on healing from suicide (Hoover & Paulson, 1999; McCormick, unpublished paper; Paproski, 1997). A study on survival factors from suicidal behaviour has also been conducted (Arato-Bollivar, 2004), but there is a difference between surviving and healing. Surviving means that the person came out alive from a difficult experience, whereas healing takes surviving one step further, it is what one does to overcome wounds from that experience. A study done by Hoover and Paulson (1999) involved gathering participants’ descriptions of their healing experience from no longer being suicidal. This study was conducted on Canadian and European participants but the researchers do not mention what ethnicity the European participants are or what defines being Canadian is? As a result of the data (Hoover & Paulson, 1999), the metaphor “A Return to Self” was established to describe the process of healing as a reconnection with the development of a new relationship to the self and new perspective on living. Crisis provided the opportunity for change and with it came the potential to reconnect to the self through internal shifts and altered perspectives; and/or through their contact and involvement with others. Contact with others frequently started the beginning of supportive emotional connection. Participants opened their ability to feel, experience their feelings, connect feelings with experiences, and develop an understanding of their experience. Participants became self-accepting, self-advancing and self-enduring the opposite of worthlessness, helplessness and hopelessness which often result in suicidal behaviour. The results of this study are similar to what McCormick (1995 & 2000) described as what healing means for First Nations people. The benefits of this study is its broad range of age of participants, 27 to 57, and the range of suicidal behaviour experienced such as suicidal thought, intent or attempt. But a more
focussed, condensed study would have been beneficial because one cannot decipher the results as being reflective of what age category or experience.

Two studies identify suicidal healing factors for First Nations youth (McCormick, unpublished paper; Paproski, 1997). Both of these studies involved adult participants who experienced suicide as a youth, the purpose of these studies was to get insight as to what they believed helped them heal from their suicidal behaviour when they were a youth. Paproski (1997) found that the instances where participants stopped themselves from attempting suicide were experiencing a sense of connection to and/or responsibility to others. The generalization of Paproski’s (1997) study is difficult because it was small (5 females) and no males were involved. McCormick (unpublished paper) found healing factors from suicide involved gaining self-esteem/self acceptance, obtaining help from others (includes friends and mental health professionals), changing thinking, expressing emotions, and connection with culture and traditions. The value of these two studies is that they focus on the strengths of First Nations youth and got insight about this problem by involving participants who experienced suicide and have healed.

Wyrostok and Paulson (2000) mention that many members of a First Nations community expect a more integrated healing experience than is offered by the compartmentalized approach of Western counselling and medicine. Successful treatment programs are those that take into account First Nations values and traditional healing approaches. There is growing evidence that these healing systems persist today because of the growing interest of First Nations people actually seeking out traditional healing because it has been shown to be effective (Wyrostok & Paulson, 2000). An example of a successful treatment program for substance abuse among Aboriginal people as described by McCormick
(2000) is one that involves cultural and spiritual revival, traditional values, and the involvement of community and family.

A study done by Wyrostok and Paulson (2000) assessed post-secondary First Nations students in Alberta about their attitudes toward traditional healing practices. Participants were asked to report their interest in, valuing of, and their experience with traditional First Nations healing practices. The participants reported a strong interest in traditional healing practices and valued First Nations healing, participants rejected the concept of traditional healing as being out-dated and strongly supported the opinion that traditional healing practices should not be forgotten. It was reported that 80% of the participants had at least some previous experience with specific traditional healing practices. These findings contribute to the growing evidence that traditional healing practices remain a vital part of First Nations healing. A strength of this study is that the instrument developed by the researchers had input by three First Nations people with cultural expertise. These experts were consulted on the instruments reconstructing, clarifying and editing.

Poonwassie and Charter (2001) have identified some traditional approaches to healing: storytelling, teaching and sharing circles, ceremonies and elders as role models. But it must also be recognized that there is great cultural diversity among First Nations groups across Canada. There are about 596 Indian bands, 2,284 reserves, 11 major language groups and more than 50 dialects (Kirmayer, 1994). First Nations groups have different traditions therefore, having an in-depth understanding and respect for the values, beliefs and practices of First Nations peoples in a specific geographical area is important to support healing practices (Poonwassie & Charter, 2001). The healing methods used by First Nations communities often reflect traditional approaches to supporting and/or healing of the members.
of that group. According to Poonwassie and Charter (2001) there is no “fixed” Aboriginal approach to support and healing. However, the approaches to healing have emerged from important cultural values that have remained intact and accepted by individuals and tribal groups.

Healing is quickly becoming a common approach that First Nations people use to overcome adversity. As more is known about, it will become integrated with other approaches to health and well-being. Initiatives that originate in a First Nations community and support a First Nations community’s worldview, culture, and tradition have proven to be most successful in meeting their peoples’ needs and in facilitating change. In order to facilitate change, those who collaborate with Aboriginal communities in healing initiatives must understand and accept their ways of healing and their worldview, and this must be accepted as equal to Euro-American therapeutic approaches (Poonwassie & Charter, 2001).

Summary of Literature Review

Reports and studies show that suicide rates among First Nations youth between the ages of 15 to 29 are well above the rate for the general population. Suicide attempts are more common than suicide completions and females are more likely to attempt suicide whereas males complete suicide more often. Suicide has impacted many First Nations communities across Canada and has always been of serious concern for First Nations people as they struggle with how to prevent suicide. Studies have shown that the rate of suicide among First Nations people is significantly high, but it is also argued that for many reasons suicides go underreported (Chandler & Lalonde, 1998; Cooper et al., 1992; Paproski, 1997).
The history of First Nations people needs to be taken into consideration to understand the suicide risk factors that have been identified among First Nations youth. Other risk factors include: lack of cultural connectedness or practicing cultural traditions, environmental factors, developmental factors, interpersonal factors, psychological factors, drug and alcohol abuse, and sexual and physical abuse. Not all of these factors contribute directly to the cause of suicide but do have a part in suicidal behaviour. For example, although in some First Nations youth suicides it was found that alcohol was involved but not determined if it was the direct cause of the suicide (as cited in the Royal Commission on Aboriginal Peoples, 1995).

It is recommended that research focus on suicide protective factors or the strengths of individuals and communities. Some First Nations communities are protected from suicide whereas in other communities suicide is problematic. Communities with a thriving culture that are less acculturated have lower suicide rates than those without a thriving culture and are more acculturated. National studies on youth suicide studies have found parental support and self-appraisal as suicide protective factors (Turner, 2001; Wagman Borowsky et al., 1999). Also, Chandler and Lalonde (1998) found self-continuity as a protective factor in Aboriginal communities with low suicide rates.

Suicide prevention and intervention programs have thus far not been successful. It has been suggested that strengthening family bonds and improving parenting skills in Aboriginal families could be a way to prevent suicide among youth (Cooper et al., 1992). One recommendation for suicide prevention is reestablishment of Aboriginal culture and traditions within communities (Chandler & Lalonde, 1998; Cooper et al., 1992; Kirmayer, et al., 2000; Minore, et al., 1991; Royal Commission on Aboriginal Peoples, 1995). Another
recommendation for suicide intervention and prevention programs is to include cultural and traditional components in mainstream therapeutic methods such as cognitive-behavioural therapy.

To understand how First Nations people can change, it is important to understand the role of healing in their culture. Healing includes those cultural and traditional practices that one can use to overcome adversity. Healing factors such as gaining self-esteem, getting help and connecting to culture have been identified to help First Nations youth heal from suicidal behaviour (McCormick, unpublished paper; Paproski, 1997).
CHAPTER III
RESEARCH METHOD

Design

Qualitative research helps come to understand and interpret how individuals in a social setting construct the world around them and the meanings people make of them (Denzin & Lincoln, 2000; Glesne & Peshkin, 1992; Palys, 1997).

The research design used in this study was qualitative. A qualitative research design explains how First Nations youth understand themselves and their experience of attempting suicide and helps seek the underlying reasons in First Nations youth’s feelings or perceptions of their experiences of what is going on (Gillham, 2000). Qualitative research produces full and integrated descriptions of First Nations youth suicidal attempt experience (Polkinghorne, 1991) and how they healed from it.

The method used in this study was phenomenological. Phenomenological is a method that allows the researcher to contact phenomena as individuals live them out and experience them (Valle & King, 1978). According to Sardello (in Valle & King, 1978):

Phenomenology is oriented toward providing a description of what can be found in the phenomena themselves. It attempts to be an analysis of what we experience as opposed to clinical “data” or experimental investigations. Phenomenology respects the phenomena as they appear, accepts them as face value (p. 141).

A phenomenological method was useful for this study because interviews could be used to gather a rich and detailed experience of First Nations youth’s experience with attempting suicide and how they healed from it. Interviews are similar to the storytelling
tradition of First Nations culture. The phenomenon was described as seen from a First
Nations youths' perspective.

The Participants

The number of participants involved was small because of the time involved in
transcribing and analyzing the large amount of data obtained from each participant (Creswell,
1998). There were twelve participants, six females and six males, age ranging from 19 to 52
years with a mean age of 35. A requirement to participate is the study was that participants
had to be over the age of 19 so that parental consent was not needed. For the purpose of this
study youth was identified as between the ages of 15-29. Most of the statistics and research
have identified this age range as having the highest occurrences of suicidal behaviour
(Chandler & Lalonde, 1998; Cooper et al., 1992; Health Canada, 1994; Paproski, 1997;
Statistics Canada, 1999). Also, the participants had to be First Nations (this could be Status
or non-status, Métis or American Indian). At the time of the study, the participant could
either be living on or off a reserve. All of the participants experienced either one or more
suicide attempts as a youth and were no longer suicidal. A requirement to participate in this
study was that the participants had already healed from their suicidal behavior and were
feeling comfortable talking about their experience. Healing was self-defined by the
participants. Most of the participants' healing should have taken place during the suicidal age
range of 15 to 29. Also, it was required that each participant had awareness and insight into
their suicidal behaviour. The choosing participants were based on a purposeful sample where
all of the participants had to meet these specific criteria (Creswell, 1998).
The participants resided in British Columbia and at the time of their suicide attempts most of the participants lived in small communities or reserves on either Vancouver Island or Northern British Columbia. Most of these communities had a population of less than 10,000 and consisted mainly of First Nations people. When compared to urban areas and the general population, the Vancouver Island and the Northern British Columbia area had the highest suicide rate among the Status Indian population and were the highest in the Province (British Columbia Vital Statistics Agency, 2002).

Recruitment

Various organizations and agencies in Vancouver, Port Alberni and Nanaimo that had contact with First Nations people were approached either in person or by telephone by the researcher and were informed of the research being done. Permission was received from the organization or agency to post a recruitment flyer in their office (Appendix B). In the case where the person-to-person contact could not be made a letter of initial contact (Appendix C) was faxed along with a flyer to the organization or agency. The flyers provided a description of the study, procedure and participant criteria. Also included on the flyer were tabs with the telephone number and email address of the researcher that could be torn off from the flyer. This method of recruitment was chosen so that those interested could obtain the information while maintaining their anonymity.

The potential participant contacted the researcher by email or telephone to schedule a date and time for an interview. When the researcher made first contacted by telephone with the potential participant they were screened to ensure they understood the study, what was

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2 The recruitment flyer, letter of initial contact, and consent form would have been on The University of British Columbia letterhead.
involved, if they fit the participant criteria and most importantly if they were healed from attempting suicide. If the potential participant mentioned they were not healed he or she would be disqualified and were provided with a list of places to receive help (Appendix E).

Once the participant qualified and expressed an interest in being part of the research the interviewee and the researcher, who was also the interviewer, agreed on an interview date, time and location.

Data Collection

The researcher was the instrument of data collection and focussed on the participants' view or meaning (Creswell, 1998). The researcher was able to focus on the participants' stories by using interviews. Interviews were the most important type of data collection method used because they provided a perspective about how the participants made sense of their world and their experiences within it (Winegardner, 1993). An ethical implication for in-depth interviewing is that is brings up powerful emotions relating to unresolved past events and this could sensitize the interviewee making them feel vulnerable and even further traumatized. Therefore, adequate training in interviewing skills and techniques was vital (King, 1996; Winegardner, 1993). The researcher is a counselling psychology student, therefore is already familiar with the skills that are necessary to help a person feel understood and comfortable during an interview. These skills include: good communication skills, good listening skills, and developing rapport and a good relationship. Although this is not a counselling situation, these skills were important to establish a sense of trust in order to obtain meaningful information from the participants (Winegardner, 1993).
Prior to the interview, a list of open-ended questions (Appendix A) was prepared that helped guide the participant and the interviewer when there was difficulty knowing where to begin or how to continue with the dialogue (Polkinghorne, 1991). The open-ended questions focussed on obtaining background and demographics information, the interviewee's experience of attempting suicide and their opinions and feelings around this experience (Patton, 1980). It is suggested that when using a list of open-ended questions, the interviewer should be aware that the actual phrasing and content of the questions might change as a result of the interviewees' unfolding description and narrative and that the interviewer needs to remain open to unexpected and new elements of the descriptions. The questions did change during the research to reflect an increased understanding of the phenomenon (Creswell, 1998; Polkinghorne, 1991). When clarification and elaboration was needed, probing questions were asked.

Each interview was a maximum of 90 minutes and audiotaped. Taping the interview focussed attention on the participant and the direction of the interview (Bassey, 1999) and it made the interview feel less formal and similar to a regular conversation. Boydan and Bicklen (1992) emphasize that a natural conversation between the two parties rather than a formal question and answer format make it easier for the interviewer to capture what is important in the minds of the participant themselves. The more the participant could be involved in the interview without any limitation or restrictions, the more the participant would feel like a contributor to the study rather than an informant (Yin, 1984).

The interviews took place at the same place where participants saw the posting. If the participant lived in a different town, the interviewer travelled to that town to do the interview. Before the interview, arrangements were made for the use of a private room at the
organization or agency where the posting was seen. Some interviews were conducted at participants’ home because that is where they felt most comfortable and safe to talk.

Once arriving at the interview site a specific protocol was conducted. Participants read and signed the consent form (Appendix D), but prior to signing, the interviewer mentioned that if the participant did not want to continue any further either with the interview or decided not to participate in the study he or she had the freedom to stop the interview at any point. The purpose of the study was explained once more, the amount of time needed to complete the interview was given, and plans for the use of the results were explained (Creswell, 1998). Then the interviewer answered any questions or concerns the participant had.

For ethical reasons, after the interview the participant was given a list of phone numbers where they could get counselling or help, in their community, if any residual feelings around the suicide came up for them afterwards (Appendix E).

Once the interview was complete, the participant was thanked for his or her time and reminded that once all of the results had been analyzed would be called to verify the results.

For confidentiality reasons and identification of each participant, each tape was labeled “Participant #1, tape 1” etc… and locked in a filing cabinet.

Data Analysis

Using a qualitative research design the data was structured using natural language rather than using the restricted descriptive repertoire of a measurement scale used by quantitative research. In qualitative research the data is not restricted to information directly related to the research question being investigated so that information about the wider
context is provided (Glesne & Peshkin, 1992). Awareness of this was important for the researcher so that the end result provided a rich and detailed understanding of how First Nations youth heal from attempting suicide.

Once the audio-recorded interviews were completed, the tapes were listened to without any interruptions. Then a transcript of each interview was typed up using word processing software. Repeatedly, the data was read while listening along with the tape, this was done until there were no more errors and the recorded data was accurately transcribed verbatim for each participant. Then, each transcript was subjected to a phenomenological analysis using a methodology developed by Colaizzi (1978), also mentioned in Creswell (1998), that identifies psychological phenomena by obtaining a descriptive as possible experience of it (Colaizzi, 1978).

All of the transcripts were read to acquire a feeling for them. At this point, the researcher noticed differences between the females’ and males’ stories of what helped them heal from attempting suicide. Therefore, the researcher decided to separate the data analysis for females and males although this was not part of the analysis and was not intended.

Significant statements, phrases and sentences were extracted from the transcripts that directly pertained to the phenomenon investigated. Significant statements were listed horizontally and each statement was treated as having equal worth. Significant statements were eliminated that contained the same or nearly the same statements. Eventually a list was developed that contained non-repetitive, overlapping statements.

The meaning of each significant statement was formulated and then grouped into meaning units, these units were listed and a textural description that describes the experience, what happened, including verbatim examples were written. At this stage, it was important
that the meanings arrived at did not sever the connection with the original description in the transcripts. It was important that the formulations of the meanings discovers and convey those meanings hidden in various contexts of the phenomena that were present in the transcripts. This part involved a creative insight on behalf of the researcher; leaping from what the participants says to what they mean (Colaizzi, 1978; Creswell, 1998).

Once the above was completed for each transcript, the meanings were organized into clusters of themes. These clusters represented themes that emerged from and were common to all of the participants' description. The themes were organized using the First Nations belief of self as interconnected with family, community, culture, nature and spiritual. If a theme did not reflect an aspect of interconnectedness it would be included as an additional theme.

These clusters were then referred back to the transcript in order to validate them. Each transcript was examined to see if there was anything in it that was not accounted for in the cluster of themes and whether the cluster consisted of something that was not in the transcript. Further examination was necessary if this was the case. At this point any discrepancies were noted among and/or between various clusters of themes. Some themes flatly contradicted other ones or appeared to be totally unrelated to other ones. The researcher then preceded with a solid conviction that what is logically inexplicable might be existentially real and valid and refused the temptations of ignoring data or themes that did not fit (Colaizzi, 1978).

The results of everything done so far were then integrated into an exhaustive description of the phenomena of how First Nations youth heal from attempting suicide. The overall description of the experience gives the essence of the phenomena. The exhaustive
description of the phenomena is as clear a statement of the essential structure of the phenomena as possible.

A final validating step was to return to the participants and asked them if the exhaustive description formulated validated their original experience. Of the 12 participants, 8 were available to validate the descriptions (four of the participants could not be located). Any new and relevant data or mistakes from this validation process were worked into the final product of the analysis.

To support the narration of the “essence” of the experience, excerpts were taken from participants’ transcripts and included in the findings; also tables were included that show the results of each process of this analysis.

Locating the Researcher

The researchers’ own experience within the chosen problem to study had derived from, most importantly, being First Nations herself. As a First Nations youth growing up in a small town on the west coast of Vancouver Island, repeatedly I heard of the many death by suicides and suicide attempts by First Nations youth that I either went to school with or knew from neighboring reserves. As a youth, who was never suicidal, I often wondered why someone so young would take his or her own lives? I wondered what was so terribly wrong in their young lives to do this? Then as a counselling psychology masters student I got the opportunity to do my practicum at a First Nations organization. Once again, the issue of suicide was at the forefront and I struggled with the same questions but, what was different was that two decades later from when I was a youth I could find answers to my questions but most importantly I could try to at least find out what could be done about this problem?
CHAPTER IV
RESULTS

By interviewing 12 First Nations adults (6 females, 6 males) who attempted suicide as a youth a phenomenological analysis of the transcripts from the audiotaped interviews began with extracting significant statements from both females and males (Tables 1 and 2), followed by formulating meanings of those statements (Tables 3 and 4). From the meanings, clusters of themes were developed based on their relation to the First Nations belief of interconnected (Tables 5 and 6). There were not any themes that were not related to this belief. The final result of the process was an exhaustive description of the essential structure of how female and male First Nations youth healed from attempting suicide (Tables 7 and 8). The exhaustive description consists of four major themes extracted from the analysis and the meaning of each of them (as indicated in Tables 3 and 4). In this study, what helped youth heal from attempting suicide centred on four themes related those being: family, community, self and culture. The results listed in all of the tables are not in any particular order.

The findings indicated that although the themes gathered were similar for both male and female participants, some of their meanings were different. Therefore, this discussion looks at females and males responses both collectively and separately. Each theme will be discussed and examples from the participant’s transcripts will be given to reinforce the description of the theme.

FAMILY

Family, as a theme (Tables 5 and 6), including extended family and friends, was mentioned in several of the significant statements (Tables 1 and 2) as an important healing factor for the participants.
| 1. Had a caring friend who supported me              | 2. Listening and talking to other youth who experienced suicide attempts |
| 3. Considered my family and how it would affect them | 4. Being able to talk to other people whom I trust                     |
| 5. Reaching out                                     | 6. Supportive family                                                  |
| 7. Reconnected with my family and friends           | 8. More self-awareness                                                |
| 9. Took responsibility for myself                   | 10. Having someone in family who is easy to talk to                    |
| 11. Having someone in family who is a good listener | 12. Having someone in family who genuinely cared about me              |
| 13. Sister accepted me for who I am                 | 14. Moving away from my village                                       |
| 15. Saw counsellor who was First Nations            | 16. Knew someone who was spiritual and traditional                    |
| 17. Got treatment for my issues                     | 18. Got involved in First Nations activities and culture              |
| 19. Helped other people in the community            | 20. Finding out I was not alone with my suicidal behaviour             |
| 21. Dealt with the issues that were bothering me differently | 22. Just accepted what happened in past                               |
| 23. Thinking differently, positively                | 24. Appreciate what I have accomplished and what I have               |
| 25. Learned to love myself and let others love me    | 26. Got a good role model                                             |
| 27. Stopped feeling sorry for myself and got out of “poor me” thing | 28. Became knowledgeable about the history of our people and culture |
| 29. Making positive life choices                    | 30. Became proud of myself and who I am                               |
| 31. Forgiveness towards those who abused me         |                                                                   |
**TABLE 2 **  SIGNIFICANT STATEMENTS: MALE

1. Thought about how my suicide attempt would have affected my family
2. Received help from grandfather or an elder
3. Gave back to the community
4. Got a better place to stay, a better environment
5. Became goal-oriented
6. One day at a time
7. Found a way to get in touch with my roots and being First Nations
8. Kept a positive attitude
9. Went to a treatment centre to improve my life
10. Had a counsellor I could tell anything to who was not judgmental, impartial but caring
11. Taking care of myself
12. Found support
13. I made a conscious decision that something had to change
14. Interacting with different people
15. Sense of self-awareness
16. Got acknowledgement
17. Kept asking for help until someone listened and wanted to help me
18. Communicated with people more openly and honestly
19. Motivation
20. Having a mentor, i.e. uncle
21. Made the right choices
22. I did everything in my power to correct my past behaviour
23. Spirituality
24. Found someone who really listened
25. Found someone who really cares
26. Took responsibility for my life
27. Appreciated what I had
TABLE 3  FORMULATED MEANINGS OF SIGNIFICANT STATEMENTS: FEMALE

1. Friends and family showed concern, that they genuinely cared for me, and supported me, which made me feel loved and to reconnect with them.
2. I had a friend, family member or someone in the community who I could trust and talk to and they would listen.
3. I had someone from my family who accepted me for who I am and my mistakes and who watched over me to make sure I didn’t make those mistakes again.
4. I entered a treatment centre, transition home or healing centre where people where willing to help me and showed they cared.
5. I could not put my family through this because I considered how it would affect them and they would have to live with the pain I left behind. The suffering would continue although my suffering would have been solved if I had really died.
6. Listening to other youth talk about their suicide attempts was inspiring because I could relate to them, it was easy to connect with them and inspiring for me because it gave me strength to heal. It also made me realize I was not alone.
7. I reached out until one person took me seriously. I sought help from my doctor, started to open up to my family and talk to friends and co-workers about what I was going through until someone listened and wanted to help me heal.
8. I had a First Nations counsellor whom I trusted and connected with.
9. I worked on my self by gaining an awareness and understanding of my self. This helped me heal by finding different, better ways to deal with my issues, my triggers. I focussed on having a positive outlook on life and thinking positively. I learned how not to take for-granted what I do have and have accomplished. I learned to love myself and let others love me. And I learned to be proud of myself and who I am.
10. I took empowerment back by taking responsibility for myself and not feeling sorry for myself, forgiving those who hurt me and accepting the past.
11. In order to find myself and to heal I had to move away from my village where all of the pain was.
12. I became involved in First Nations traditions and culture by participating in or observing activities. I also educated myself and became knowledgeable about my culture and the history of our people. This helped me understand what I was going through and how to gain strength.
13. Kept myself busy by volunteering in the community, doing good stuff that helped other people. This made me feel a sense of belonging and pride in myself.
14. Received guidance by a mentor. Having someone there that understood what I was going through helped me make the right choices.
TABLE 4  FORMULATED MEANINGS OF SIGNIFICANT STATEMENTS:
MALE

1. Thought about how my suicide would have affected my family afterwards. Becoming aware that my actions would hurt more people than I intended and how it would solve my problems and not my family's problems.
2. Found love, comfort, wisdom, spirituality and acceptance from an elder by helping them, accepting their help and guidance and gaining knowledge through them. Especially, a grandfather.
3. Participated in functions and volunteered in the community. This allowed me to help other people and give back to the community. This made me feel like a new me, a sense of self-awareness. I learned new things, I received acknowledgement, it was uplifting. I felt like I belonged and was a part of the community and it was gratifying to help other people.
4. Had to change my environment, get away from my reserve. There was nothing there, no jobs, only drugs and drinking. It allowed me to break the cycle I was in. There was no privacy because everybody knew your business. Being in a different environment allowed me to meet all sorts of new people and find new opportunities. I felt accepted and I could trust people in the new community.
5. Staying day-to-day allowed me to become goal-oriented and stick to my goals without feeling overwhelmed and confused. I stuck with my goals of figuring out what I was doing to myself, where I wanted to go, and who I am by taking them one step at a time and one day at a time.
6. Found a way to get in touch with my culture and being First Nations. I learned songs, attended ceremonies, did native art, and educated myself on First Nations history. This gave me a sense of pride in who I was and where I came from.
7. Pursued a more positive way to live life and kept a positive attitude. The more positive I remained the more positive things came my way and the type of people I was attracting changed. Made me feel better about myself, I felt more hopeful.
8. Entered into a healing centre, treatment centre, participated in groups, took self-help programs. These programs provided me with useful life tools that I could use in my everyday life and how to deal with my issues. Helped me changed my destructive behaviour.
9. Started seeing a First Nations counsellor. This was valuable for me because I had the opportunity to talk to someone who cared, was not judgmental and was impartial. Made me feel good to know I had someone out there I could rely on to be there for me.
10. Took care of myself first by dealing with my own problems and losses. This allowed me to find love for my self.
11. Had a mother that listened and showed she cared. Had a girlfriend that helped me get through the worst, and friends who always watched over me. This made me feel like I mattered and was not alone.
12. Had a mentor such as an elder or relative that provided me with wisdom and helped me understand the way things are. Gave me clarity about my problems.
13. Received acknowledgement from people in the community. I was getting the attention I have been missing in my life and I felt like I mattered.
14. Kept asking for help until someone listened and wanted to help me. Knowing that there was help out there, I just needed to remain determined to find it. Reaching out for help kept me motivated to strive for a better life and make a difference in it.

15. Communicating my feelings and being open and honest with people gave me empowerment.

16. Took responsibility for my life and behavior. I admitted my mistakes, ensured they never happened again, accepted that past, and quit blaming people. This allowed me to take power back from the negativity in my life and make changes to get out of the rut I was in. This was a conscious decision that I made, that something had to change. It was all up to me.

17. Became proud of my accomplishments that I made as I healed and appreciated what I had, made me realize life was not all that bad.
TABLE 5  CLUSTER OF COMMON THEMES: FEMALE

Family
1. Family and friends show concern and show they genuinely care for the youth.
2. Family and friends give the youth support and want to help the youth heal.
3. Importance of having a family member or friend who can be trusted.
4. Being able to talk openly with family and friends and feel listened to.
5. Considering how suicide would affect family and friends when the youth is gone.
6. Receiving guidance from a mentor either from inside or outside of youth’s family.
7. Youth has comfort in knowing that someone is taking care of them by watching over the youth.
8. Reconnecting with family and friends.

Community
1. Participating in a program that suits the youth’s needs.
2. Talking with and listening to other youth share their experience with suicide attempts allows youth to feel like they are not alone and connect.
3. Having a First Nations counsellor who genuinely cares and wants to help, can provide trust and a connection with the youth.
4. Volunteering in the community.
5. Changing environment, moving away from reserve or community.
6. Youth can establish trust within the community.

Self
1. Reaching out until one person takes the youth seriously.
2. Communicating feelings to family and friends.
3. Youth acquires self-awareness and understanding of one’s self.
4. Having a positive outlook on life and thinking positively.
5. Learning how not to take for-granted what one has and her accomplishments.
6. Youth learns how to love one’s self and life.
7. Youth gains empowerment by taking responsibility for one’s life, forgiveness, accepting the past and letting go of self-pity.

Culture
1. Involvement in First Nations traditions and culture by participating in or observing activities.
2. Becoming educated and knowledgeable about one’s own culture and history of First Nations people.
TABLE 6  CLUSTER OF COMMON THEMES: MALE

Family
1. Considering how suicide would affect family and friends when individual is gone.
2. Receiving wisdom from and helping an elder, especially a grandfather.
3. Having a family member, friend, partner who made individual feel like he matters by acknowledging the individual and giving him attention.
4. Communication amongst family, friends, relatives and community.
5. Receiving guidance from a mentor.
6. Youth knows that someone is watching over him.

Community
1. Volunteering in the community.
2. Participating in a program that suits the youth’s needs.
3. Having a First Nations counsellor who genuinely cares and wants to help, can provide trust and a connection with the youth.
4. Changing environment, moving away from reserve or community.
5. Trust within the community.
6. Acceptance within the community.
7. Making connections in community that are helpful and positive ones.

Self
1. Reaching goals by staying focussed on taking one step at a time and one day at a time.
2. Having a positive outlook on life and thinking positively.
3. Taking care of self first by dealing with own problems and loses.
5. Being persistent and determined about asking for help until someone listens and wants to help.
6. Gaining empowerment by communicating feelings and being open and honest with people.
7. Gaining empowerment by taking responsibility for one’s life, forgiveness, accepting the past and letting go of self-pity.
8. Making a conscious decision that something has to change.

Culture
1. Involvement in First Nations traditions and culture by participating in or observing activities.
2. Becoming educated and knowledgeable about one’s own culture and history of First Nations people.
TABLE 7  EXHAUSTIVE DESCRIPTION OF HEALING FROM ATTEMPTING SUICIDE: FEMALE YOUTH

For female First Nations youth, reconnecting with family and friends is considerably important in helping them heal from attempting suicide. Help from family, especially immediate, and friends are useful when trust is established. Trust in family and friends comes from showing their concern for the youth and that they genuinely care and by offering support and wanting to help the youth heal from attempting suicide. Once trust is evident, the youth is able to talk openly with family and friends and feel they are listened to. Female youth also have comfort in knowing that someone, either a friend or family member, wants to help guide them in the right direction, this friend or family member may even take the role of mentor for the youth. Female youth, not only consider their needs and wants when it comes to healing from suicide attempts, but they also take into consideration how their death by suicide would affect their family and friends. Belonging to a community that offers support by having First Nations counsellors who provide trust and show they genuinely care for and want to help the youth is important, as well as, having programs that are suited to the needs of youth. There is value in giving back to the community by way of volunteering and becoming involved in events that are of interest to the youth. Connections with other youth who have gone through the same experience is valuable because it allows the youth to share their stories, listen to others and have a sense that they are not alone in their feelings. Sometimes, it is necessary for the female youth to move away from her community in order to establish these needs from a community. In addition to external sources of healing, youth also need to identify what they need to do internally in order to heal from suicide attempts. This may involve developing self-awareness and understanding toward what helps or hinders the youth from loving themselves and life. Learning how not to take for-granted what one has and accomplishments is important for having a positive outlook on life and thinking more positively. Taking responsibility for one’s life, forgiving those that hurt the youth, accepting the past and letting go of self-pity are all important factors for the youth in gaining empowerment. Having the courage to reach out to someone and communicating feelings toward family and friends are also fundamental toward the youth’s healing process. First Nations traditions and culture may be healing when one participates or observes activities and/or becoming educated about the culture and history of First Nations people. This may provide a sense of belonging, pride and understanding concerning how colonialism affects First Nation peoples.
For male First Nations youth, support during the healing process from suicide attempts comes from outside the immediate family, usually external family, friends or community members. Having family, friends or a partner who makes the youth feel he matters by acknowledging the youth and providing attention is important. Additionally, communication of feelings, problems, issues and concerns among family, friends and community is a valuable source of healing for male youth. Also having comfort in knowing that someone, either a friend or family member, wants to help guide them in the right direction, this friend or family member may even take the role of mentor for the youth. Important for male youth is receiving wisdom, knowledge and guidance from an elder, especially a grandfather. A relationship with an elder is a valuable relationship to have during the youth’s healing from suicide attempts. Male youth, not only consider their needs and wants when it comes to healing from suicide attempts, but they also take into consideration how their death by suicide would affect their family and friends. Male youth value the connections they make in the community. It appears important for First Nations male youth to be accepted by members of the community, which helps them build trust in the people and the help that is available in the community. Belonging to a community that offers support in the way of having First Nations counsellors who provide trust and show they genuinely care for and want to help the youth is important, as well as, having programs that are suited to the needs of youth. There is also value in giving back to the community by way of volunteering and becoming involved in events that are of interest to the youth. Sometimes, it is necessary for the male youth to move away from his community in order to establish these needs from another community. In addition to external sources of healing, youth have identified internal sources needed to heal from suicide attempts. The precursor to healing from suicide attempts is making a conscious decision that something has to change. This may involve developing self-awareness and an understanding toward what helps or hinders the male youth from loving themselves. Also, learning how to have a positive outlook on life and thinking more positively is valuable. This may contribute to developing goals and being able to dream which will be a source of motivation for the youth to heal. This is accomplished by taking one step at a time and one day at a time. Taking responsibility for one’s life, forgiving those that hurt the youth, accepting the past and letting go of self-pity are all important factors for the youth in gaining empowerment. As well as, gaining empowerment by communicating feelings and being open and honest with people. First Nations traditions and culture may be healing when one participates or observes activities and/or becoming educated about the culture and history of First Nations people. This may provide a sense of belonging, pride and understanding how colonialism affects First Nation peoples.
Both female and male participants felt what helped them heal from their suicide attempts was taking into consideration how their death by suicide would affect immediate and extended family and friends. As a youth, the participants had awareness that if their attempt did result in death it would solve their problems but make matters worse for family or friends because they would be left with the grief of their death. Another similarity that both male and female participants mentioned was being comfortable to communicate their own feelings, concerns, emotions, and issues to family and friends, and knowing that they would reciprocate. It was important that communication among family and friends was done in a healthy and respectful manner that enhanced the relationship.

*Example:*

We [participant and father] are really good friends now, we can talk about anything and me and my mom too hey. This has healed some of the wounds…Not everything is all good, but hey I can speak to them.

Having a mentor in the participant’s life when they were a youth helped guide them to make the right choice and provided insight and wisdom, which was a valuable relationship for healing. The mentor was either an immediate family member such as an older sister or extended family member such as an uncle or cousin. Sometimes it involved someone in the community that went through their own healing but not necessarily suicide attempts, for example, a transition house worker. A mentor was someone whom participant connected with, trusted and felt cared for by him or her. The mentor was not into advice giving; they did give suggestions and but not force them to do anything. The mentor would put the idea out
there and let them decide for themselves. The mentor was also someone the participants said they felt completely at ease with because they felt accepted.

Both female and male participants mention having comfort in knowing that someone was taking care of them by watching over them. For female participants this person was usually a family member and for the male participants this person was usually a friend. A kind statement from someone like "I will pray for you", "I care about you" or "I will always think about you" was what the participants needed to hear to feel a sense of being watched over. This meant that they never really felt alone and that there was someone out there who was concerned for them. Having comfort in being watched over also came from someone showing concern for the participants' well being such as making certain they were eating right or staying on track with their healing.

*Examples:*

Like she's there spiritually...I felt good about it because I knew she's always watching over me...If like something scary was going to happen to me or something, then she was there like she knew something was going to happen.

I had friends ...watch over me all the time. Making sure I am eating. That's all I needed...Then they say, "Hey, somebody cares." That's all that kept me from thinking...hey nobody even thinks twice about me, why should I even stick around.

The meaning of how family and friends helped the participants heal from attempting suicide was different for the females and males. For female participants, reconnecting with friends and family played an important role in their healing from suicide attempts. It was
important that family and friends showed concern and that they genuinely cared for them.
Also, of importance was the support that family and friends gave and that they really wanted
to help them heal. These factors were important for the reconnection to be established or if
that connection was already there, the participants would turn to family and friends because
of these qualities. To go to family and friends for help, there had to be trust in them or at least
trust in one family member or friend. For the females, trust in a family or with friends meant
a feeling of connectedness and safety.

The male participants usually went outside of the immediate family for support and
help when healing from their suicide attempts. They sometimes felt that their family was not
there for them, therefore, they looked elsewhere for their support. The male participants felt
they could trust friends, extended family or people in the community more than their family.
Later when they had healed they might reconnect with family, but for the most part of their
healing they remained disconnected from family and relied on other connections. For a male
to want to turn to someone close for help, such as a family member, friend or a partner, he
would have to feel like he mattered. The males recognized they mattered when they received
acknowledgment and attention from loved ones. A significant relationship for most male
participants was with a grandfather or male elder. Gaining wisdom and taking care of their
elder was rewarding for these participants, and it also gave them strength to continue healing.
The male participants mentioned that they felt respected by the elder and they gave respect
back.

Examples:
I looked after him...I kept him warm, chopped wood and stuff like that, went out in the boat
with him. That really kept me going.
They got my respect and I got their respect because I showed them I wanted to help them out. That's why they're the ones that really made me strong.

I would sit around with my grandfather for quite a few hours sometimes and he would talk to me in our language. I could understand it. I would speak a bit of it. It was his way of healing me.

COMMUNITY

Community, as a theme (Tables 5 and 6), included external resources that were of value to participants when healing from attempting suicide. These external resources included people in the community and programs and services. For both female and male participants, there were many similarities in regard to how community helped them heal. Participation in a program was helpful. It was important to find a program that suited their needs whether that was dealing with anger, sexual abuse or addictions. Many of the programs or services the participants attended were specifically for First Nations people and were relevant to First Nations culture and traditions. Those who attended these programs and services found them useful and stayed with it because they would feel like they mattered and were cared for by the people who ran the programs and services. It gave them the opportunity to find a safe place to open up about their feelings and learn how to make the necessary changes in their lives so they could heal.
Examples:

So I went to treatment centres...I did learn something...fully participating in everything...I was getting something out of it. Basically just getting into these small groups and talking about our selves...I could get into a group setting and I could just go right back there...and I could feel the feelings.

I took three anger management courses and I must say, it accomplished a lot. I was fighting everyday before I went to those...I would highly suggest that anger management, is very good. I enjoyed it.

Of the services that were available in the community, counselling was an important service for healing from attempting suicide. Trust and forming a connection were essential toward reaching out to someone for help and especially important in a counsellor. Trust and connections were formed between the counsellor and participant when the counsellor showed he or she genuinely cared and wanted to help. Usually these counsellors were also First Nations. The participants appreciated a counsellor who was not stringent in applying traditional Western therapeutic approaches in counselling. They valued a counsellor who did not enforce their own agenda and were able to adapt to their needs in the counselling session. Usually, being a good listener was enough to make them feel understood and not judged. A common regret made by the participants was not having found this type of service when they first became suicidal as a youth.
Examples:

If it wasn’t for that counsellor that would have been it… I got the impression that she was a big sister I didn’t have. I could tell her anything. She won’t judge me, that was something… Every time I walked out of there I started heading home I would have a smile on my face. She was uplifting… the main thing was the counselling and just having someone to talk to, someone impartial… seemed not to pass judgment.

I felt a connection with her the way I felt with my sister. Its like I talk to her and she would tell things that would just open me up and I tell her everything I was thinking, everything that’s going through my mind. I usually don’t connect with anybody like that to tell my deepest feelings and that.

Another way participants reached out to the community to heal from attempting suicide was by becoming more involved in the community and this was done by volunteering in activities, organizations, events and supporting causes. Volunteering in the community provided them with acknowledgement and respect from community members. Also, volunteering in something that they were interested in gave them enthusiasm for life, something to feel excited and compassionate about. The participants described the volunteer work as a way to learn new things about society and themselves such as their capabilities. Volunteering was not just about what it did for the participants but also what they could do for the community. It was their way of giving back to the community. Many of the participants mentioned that they enjoyed helping other people. Some felt this was what they were meant to do and wanted to dedicate their time to helping others because they felt they
did have something to offer the community. Volunteering their time to help others allowed the participants to become recognized in the community as someone who cares about people and wants to help, the same qualities they looked for in people when they wanted help. Some of the participants mentioned they eventually became role models for those they were helping.

For the participants who volunteered, some took on important responsibilities. Some became board members, some were responsible for fundraising, or some started their own peer group. Having responsibility and doing well at it gave them the validation they needed to realize that they could change and life could be better than what it used to be. Also, being a part of the community allowed the participants to feel they not only belonged, but they were also accepted, this was especially important for the males.

_Examples:_

I got asked to sit on the board of a First Nations women’s group...Doing workshops and conferences with youth. We’d make kids on the street Christmas dinner...There were a lot of people who looked up to me in the community.

I went to that squat. I really came out of my shell at that point. I was there for support. I did some fundraising for them. I brought in over $8500 in donations single handedly...Generally, I just felt the need to be acknowledged. I wanted to learn things...I was meeting people. These new people showed me new things. Gave me a new sense of self-awareness, like a new me so to speak. I just needed that chance....
Whereas the female participants received their meaningful connections with family and friends, male participants valued the connections they made with other people in the community. They sought connections that would be helpful for them and be a positive influence for them. This was important for making those changes needed to be able to refrain from suicidal behaviour.

Example:
The people here have open ears, they listen to you. They try to help you in any way that they can...are closer than my family, my ex old family...I could trust a person in the community more than I could trust my family.

For female participants, connections in the community came from talking with and listening to other youth share their suicidal experience. This made the females feel like they were not alone in their feelings and their experience with attempting suicide.

Example:
I think one thing that really got to me was hearing this girl, she was about 15, went up and talked about suicide...That really made me think about me...I was a really stubborn person but this girl really got to me...it gave me more strength you know to keep going...she really got through to me...I really related to her at the same age trying to commit suicide all the time.

Changing communities or moving away from a reserve was important for some participants to do if they wanted to make positive changes in their lives and heal from suicide attempts. Moving away from the community was important because most of the time the
community or reserve would be were the participant experienced trauma, abuse or had unhealthy relationships with family. Also, being in a small community meant that many people knew their business and their problems. There was no privacy. Another issue experienced by the participants who decided to move away from their community was the lack of employment and feeling like there were not many opportunities for them to get ahead in life. Some participants felt their future in their community looked bleak and would consist of relying on drugs and alcohol and welfare to get by, therefore, moving away was a wise choice. For some communities there were not sufficient resources or services available for them to go to for help. To get their healing needs met this meant that moving from a community or reserve was necessary.

Examples:

I was better off down here because I was not so depressed all the time, hurting all the time because being in the village there...that is where I was hurt as a child and it just... bad spirits for me being there.

All I need is to get out of town. She helped me out...Got me out of town. I was grateful for her doing that. She saved me a lot of pain and suffering because it was a long, vicious cycle I was going through living there.

Sometimes all you need to do is get a better place to stay. Better environment. For youth on reserve, where all your problems are magnified, everyday you have to wake up and you’re in the spotlight and everybody on the reserve knows your business, I couldn’t handle that. On the reserve you can’t get away from your problems.
In addition to the external factors that helped the participants heal from attempting suicide were changing aspects of the self. Self, as a theme (Tables 5 and 6), included internal factors that also helped participants heal. They wanted to know what made them suicidal? And how they could change that from within? These internal factors involved taking inventory of themselves and what they could do to change the self. For many of the participants one step was to understand themselves better and to acquire self-awareness. Some of the participants did this alone and others did this with the help of a counsellor or by attending a program. The desire to have a self-understanding and self-awareness came from wanting to find better ways of handling situations that they reacted to or were triggered by in a negative way. The way they were reacting was not benefiting them and was keeping them stuck in old patterns, such as continuously attempting suicide or getting into fights.

Examples:

I seen patterns of suicide coming up, I just felt that it would be best for me to walk away from that situation before it turns back on me. Before their (referring to friends) pain, their depression started influencing me. I changed, I couldn’t help it.

If I started to get depressed at all, I’d deal with it, I talked to somebody, or changed whatever was bothering me or got myself out of the situation that was depressing me or whatever. Just being aware.

Most of the participants acknowledged that they would not be able to heal completely on their own and would need outside help. But trust was an issue and was something they
valued from other people. Although their experiences with trust were not always positive they knew they had to be determined and persevere when it came to reaching out for help. It was important for the participants to not give up until they found someone who they could trust and who sincerely wanted to help them. As a result of their determination and perseverance the participants were usually successful at finding the help they were looking for.

Example:

I could have sat there by myself and chosen not to scream or anything, I could have just sat there and sulked and dwelled on that suicidal thought. I could have even acted on it, who knows? If I really wanted help, start yelling, kicking and screaming around. I was bound to get attention from somebody. You never know. I might get the right attention from the right person. That person might get me out of that hole. If I didn’t like the help he was giving me I could tell him no, I’ll stay here; I’ll wait for something else to come along... The only way to get help is to actually ask for help. You can’t expect someone to put your hand up for you.

Gaining empowerment for the participants meant taking responsibility for their own lives and this was done by focussing their energy on themselves instead of focussing on those that hurt them or what they could not change. For some participants in this study, taking responsibility for his or her life also meant taking control back. For many participants, empowerment involved forgiving those who had hurt them. Forgiveness was expressed either by directly telling the person they were forgiven, writing them a letter or acknowledging it to themselves that they forgave somebody. Shifting from blame to forgiving was powerful for
the participants because with the blame came a lot of anger but with forgiveness came compassion and freedom.

Empowerment also came from accepting the past as something that happened that they could not change and letting go of it instead of dwelling on it most of the time. Letting go of the past did not mean completely forgetting it; it meant learning from it and how they could do things differently to better their lives and not make the same mistakes twice. Another part of gaining empowerment back by accepting the past was that it allowed the participant to stop feeling sorry for themselves because of the life they had. This meant moving from self-pity to self-acceptance and having love for themselves and life. Additionally, for the male participants, empowerment also meant communicating their feelings and being open and honest with people about their feelings.

Examples:

Just giving up power to the person who abused me, knowing that I am letting them have power over me...I don’t want them to have that power. I took empowerment back from them by not continuing to commit suicide.

I found a better way...once you have done wrong and forgave yourself you can get a lot accomplished. Admitting your mistakes and just knowing you won’t let it happen again. Just taking control, taking my power back from the negativity. Everyone has so much power within themselves. Just let your heart be open. It can take you so far. That’s what got me to where I am today.
I learned to forgive and not be angry with them anymore. I don’t blame them for anything that has happened in the past... For me to start healing, I had to forgive.

The thought process of participants also had an impact on their behaviour that would lead to suicide attempts. They felt that much of their thoughts were consumed with negativity. There was negativity about the past, about themselves, about life, and especially about the future. They recognized their thinking patterns were not doing them any good because they would lead to depression, anger or other negative feelings, and eventually suicide attempts. The participants knew they needed to change their thinking if they wanted to heal. By changing their thinking and striving for a positive life, the participants felt their life became different. At first, this change was difficult for many participants, but they did notice a difference when their thinking patterns changed. They were attracting positive people; they became more noticeable and positive life opportunities opened up for them.

*Example:*
I learned to identify where I was going with my thinking. Because I knew when I was suicidal at that time, I lived in a fantasy world... “if only,” that’s the kind of life I lived... I would catch myself thinking like that, woo, woo, no, no I am not going there... That’s what helped me get through life because if I started thinking “I wish” then it was like get with the program hey! Life sucks hey but I got up every morning determined to make it better.

There are differences between the female and male participants in regards to certain aspects about themselves they felt needed changing. For the females it was learning not to take for-granted what they have and their accomplishments. This meant recognizing that they
had supportive and caring family and friends by their side helping them heal. They had someone close to turn to when times were difficult. For some, they were young mothers and they could not take for-granted that they needed to take care of that child and give them a good life. Some accomplishments they became aware of as important to them were finishing high school, having a job, or overcoming difficult life obstacles, such as being sober or drug free.

Examples:

I was never proud of who I was and what I accomplished in life and what I have. I was never once...I am rich, I have family that I love and they love me back, I have friends, very close friends.

Just realizing that life is wonderful, even though you have a few crappy times. Stuff will happen...I have this great son...a lot of people who love me, so just realizing I took it for-granted before, but now I value that. A lot of growing up.

The female participants also mentioned having the courage to share their life experiences and talk more openly about their life to people as a way of healing. This was challenging for most because of lack of trust, but sharing their story was something they felt they wanted to do because they were tired of being silent. Talking about their lives was healing and sharing it with others allowed for connections and the possibility of affecting another person and giving them the courage to speak up too. But usually, just having the courage to talk openly was all they needed and it made them feel better about themselves.
Example:

Not having anybody to talk to was a problem. It came to a point where I chose to speak to somebody. I am totally comfortable with that now. I couldn’t be embarrassed anymore, because that was where I was at in my life. I have had nothing but compliments on my character alone, for the fact that I’m a very strong woman.

Regarding the male participants, they mentioned that their first step in recognizing that they wanted to heal from attempting suicidal was that they had to make a conscious decision that something had to change. Once the decision was made that they wanted to change it was important to them that they stay motivated at making those changes. Setting goals and reaching those goals kept them focussed. Most of the males would accomplish their healing goals by staying focussed at taking one step at a time, one day at a time and one problem at a time. This also meant that they had to put themselves first and take care of themselves first by dealing with their own problems and losses and not to allow themselves to get lost in other people’s lives or relying on others to make them happy.

Example:

Obviously that kind of life didn’t work. I didn’t get anywhere doing that. I made a conscious decision that something has got to change, I have to make the difference...Being goal oriented...wanting to make the difference, being a part of the solution, not the problem. I really never saw myself in a dark place again.
CULTURE

Culture, as a theme (Tables 5 and 6), for some of the participants, did help in their healing from attempting suicide. Culture, in this study, was defined as those cultural practices participants participated in or observed. Being involved in their culture gave them a sense of pride in who they are. Some of the cultural traditions the participants mention they became involved in to help them heal were: seeking traditional and spiritual guidance from an elder, helping family with their art or even learning First Nations art in the form of carvings, fishing or smoking salmon. Some participants sought healing in culture by attending sweats, Powwows, Potlatches or smudging. Other cultural activities included prayer and learning songs and dances.

Becoming in touch with their culture and their roots also meant that some participants found the desire to read up on First Nations people or talk to other people either in their family or community about their culture and roots. Getting involved in their culture again also increased their knowledge of the effects that colonialism had on First Nations people and how that affects them today. Learning about their culture by listening to elders was especially valuable and healing. For some of the participants, learning about and getting involved in their culture helped them heal because it allowed them to find out who they are and give them an identity.

Examples:
I got into my culture. I learned. I bought books, I went home up north, to find out about my Nation, the language and stuff like that. Because it was all taken away from us.
To be the real me... I just found a way to do that by really getting in touch with my roots and being First Nations, on how powerful that is, just experiencing cultural and ceremonial events, how it can impact your life. I took up Native art and carved my first mask, it turned out beautiful. I started learning songs... It's mine to be a part of a culture, see who your people are and how they lived... That's what got me through everything.

Once I learned to educate myself, that it was apparent in all, or most, First Nations family histories. It's all revolved around their parents and their parents. A lot of it started in residential schools. So the dysfunction occurred centuries back. All it takes is a desire to change that. You learn you can do better.
Summary of the Results

Interviews of 12 adult First Nations adult participants (six females, six males) living in British Columbia were done to explore how they healed from attempting suicide as a youth. The data collected was analyzed by working inductively from particularly significant statements, to the meaning of those statements, to specific themes as they related to the First Nations belief of interconnectedness, and finally resulting in an exhaustive description of their experiences. There were 31 female significant statements and 27 male significant statements. The cluster of themes extracted from the formulated meanings of significant statements were in relation to family, community, self and culture. The final result was an exhaustive description of all of the themes. Themes that did not related to interconnectedness were not found.

The purpose of this study was not to compare females and males. But, because there was equal representation of males as there were females and because there were differences in healing factors or different meanings of them, it seemed appropriate to do so. This would be useful for determining what would help a suicidal female versus a suicidal male.

Limitations and Delimitations

There are several factors that limit the findings of this research. It is difficult to generalize from the results because of the number of participant. Although qualitative research requires a small number of participants, most of the participants were from British
Columbia and further, large scale research would be required to include participants that represented First Nations from across Canada before the themes could be generalized. A delimitation in regards to the number of participants is that it did include equal representation of females and males, which does not seem to be the case of past research on the same topic.

Another limitation is that the data was based on interviews, which meant that participants had to recall their suicidal events. The time frame for the occurrence of this event in this research ranged from 6 months to 30 years ago. Therefore, the accuracy of the reporting of the events has to be taken into consideration. Specific details may have only been brought back to memory and other details forgotten about or not mentioned because it may not have seemed important to the participant. There is also the possibility that healing factors related to events, places or people might have been inaccurately reported because of the time lapse. Nevertheless, remembering important and life-changing events could be a delimitation. Details of significant, life-altering events may remain quite vivid in the participant’s recollection of the event.

Finally, another limitation in this research was the instrument for collecting data. Face-to-face interviews were done with each participant and it is possible that the interviewer may not have been conscious of the effects of listening actively with the use of head nods or “uh huhs.” The participant may have seen these actions as agreements or signs to give more detail and reacted to them.

Implications for Research and Theory

In regards to the literature on how First Nations youth heal from suicide attempts the results of this study both confirm some of the other research related to this topic and expand
upon it also. Suicidal healing factors mentioned by other researchers include experiencing a
sense of connection to and/or responsibility to others, gaining self-esteem/self-acceptance,
obtaining help from others (includes friends and mental health professionals), changing
thinking, expressing emotions, and connection with culture and traditions (Hoover &
Paulson, 1999; McCormick, unpublished paper; Paproski, 1997). These healing factors were
empirically supported in this study with the emergence of the following themes: Connecting
or reconnecting with family, friends and community, considering how suicide would affect
family and friends, learning to love oneself, taking responsibility for actions, reaching out for
help, changing thinking, communicating feelings, and involvement in culture and traditions.
In addition, this research identified other healing factors not mentioned in previous research
such as: volunteering in the community, forgiveness, changing environment, participating in
programs, persistence and determination to change, and guidance from an elder.

Some of the results of this research do not support certain healing factors as identified
in other research on this topic (Hoover & Paulson, 1999; McCormick, unpublished paper;
Paproski, 1997). In other research reconnecting with culture and traditions were important
healing factors, especially spirituality. In this research, connecting with culture and traditions
were mentioned but only by a few of the participants. Culture and traditions in this study
were defined as cultural practices that people participated in or observed such as Sweat
lodges, smudges or Pow-wows. Also, spirituality did not appear to be an important healing
factor, again only for a few of the participants but not enough to make it as important as
family, community and self.

Once the meanings were formulated from the significant statements in this study it
was recognized that the cluster of themes fit with the belief of interconnectedness in First
Nations culture and the values of the self and its connection to all of creation. Creation includes family, community, culture, nature and spirituality. Nature did not come up at all as a healing factor in this study, but self, family and community were mentioned repeatedly by the participants and few did mention spirituality and culture. Healing involves a reconnection to culture, family, community, spirituality and nature. These aspects of healing are what provide Aboriginal people with meaning of what it is to be Aboriginal and their cultural values (McCormick, 1995 & 2000). Although culture did not appear important for the participants in this study, the data indicated this cultural belief of self and interconnectedness to all of creation, especially with family and community, existed as important healing factors for attempting suicide.

The results of this research have important implications for the application of appropriate approaches to counselling and mental health treatment. Thus far, Western therapy approaches have not been successful in helping First Nations people as the theory behind many of these approaches are based on the individualistic worldview of the dominant culture (Johnson & Tomren, 1999; LaFromboise & Graff Low, 1998). First Nations worldview of being a collectivistic society is the opposite from the dominant worldview. Therefore, First Nations culture and traditions needs to be taken into consideration when applying counselling and mental health treatments to First Nations people. Some Western theoretical approaches to counselling and therapy have been recognized as practical therapeutic methods for First Nations people such as cognitive-behavioural therapy and systems theory for family therapy (LaFromboise & Bigfoot, 1988). When using these therapies for suicidal First Nations youth an important element to include in these approaches is an understanding of what helps First Nations youth in particular heal from attempting
suicide. The suicidal attempt healing factors such as those identified in this study would be
from their worldview and not the dominant societies, therefore making them more effective
and beneficial for incorporating into therapeutic approaches.

Implications for Practice

This research has implications for developing suicidal intervention and prevention
programs for use in First Nations communities. Understanding what helped First Nations
youth heal from their suicide attempts and what is of value to them could be applied to
preventative and intervention programs for this cultural group. With programs that foster the
suicide attempt healing factors from this study and others there would be a possibility of
reducing suicide behaviours in First Nations youth.

Polkinghorne (1991) states that the illuminations, understanding and extrapolations
derived from qualitative research are useful for the practice of counselling psychology. Those
counselling psychologists who work within the First Nations communities and are aware of
suicidal healing factors will be better equipped when they come across a suicidal youth
because the counsellor will know what needs to be done to help that youth heal themselves
from suicide attempts or prevent it from happening. But, counsellors should take caution and
not immediately assume every First Nations client who is suicidal prefers culturally based
treatment.

Often First Nations youth have no choice but to see a non-First Nations counsellor.
Non-First Nations counsellors need to recognize that their trustworthiness may be in question
(Skouras, 1998). Counsellors who understand suicidal healing factors for First Nations youth
and especially what these youth expect from a counsellor and counselling experience would
help improve their compliance to counselling. Counsellors who refrain from making ethnocentric judgments and enforcing western counselling methods would be more successful at gaining the trust of their clients and promoting change in them.

This research also has implications for practice in First Nations communities. For many communities suicide is a problem and there are hardly any successful solutions for alleviating this problem (Garland & Zigler, 1993; Hoover & Paulson, 1999; Kirmayer, 1994; LaFromboise & Bigfoot, 1988). Communities could use the findings of this study to develop their own programs. They already have the expertise of healing factors such as cultural values and tradition, they would just have to incorporate the Western methods. A suicidal prevention and intervention program that is developed by its own community and based on First Nations healing factors would probably be more successful that one that is brought from outside into the community.

The results of this study also have important implications for educating mental health workers on what helps First Nations youth heal from suicide attempts. Training could be provided to those mental health workers who work with suicidal First Nations youth based on these results.

Implications for Further Research

Additional research on this topic would benefit from expanding the generalization of the results to other First Nations youth across Canada and increasing the number of participants. Perhaps a different research method could be used in order to accomplish this. Replication of this study would reinforce the findings here and perhaps additional healing factors would be found. Outcome research that examines the suicidal healing factors found in
this study used in counselling or programs would determine the usefulness of these results as they pertain to practice. Research of how these results apply to other serious problems among First Nations youth i.e., alcohol and drug abuse could be explored and this would produce healing factors that could be applied to a wider range of problems or various types of programs.

Summary

The purpose of this study was to do an in-depth qualitative exploration of what factors helped First Nation youth heal from attempting suicide from their own perspective. To understand the healing factors it was important that this study produce themes and the meaning of those themes that would best describe how First Nations youth healed.

The research method used was phenomenological (Collaizzi, 1978; Creswell, 1998; Valle & King, 1978). Interviews of 12 adult First Nations participants (six females, six males) living in British Columbia were done to explore how they healed from attempting suicide as a youth. The data collected was analyzed by working inductively from particular significant statements, to the meaning of those statements, to specific themes as they related to the First Nations belief of interconnectedness, and finally to an exhaustive description of their experience. There were 31 female significant statements and 27 male significant statements. The cluster of themes extracted, as they related to the First Nations belief of interconnectedness, from the formulated meanings of significant statements for both females and males were in relation to family, community, self and culture. The final result was an exhaustive description of all of the themes.
The findings of this study contribute to the field of counselling psychology by providing an understanding of what helps First Nations youth heal from attempting suicide and what those healing factors mean to the youth that make them important. These findings have implications for both practice and research. Counsellors will be able to better assist First Nations youth and suicide prevention and intervention programs could be developed around these findings. Further research will confirm and add to this study.
REFERENCES


Interview Questions

1. How old are you?
2. What band are you from?
3. How many times have you attempted suicide?
4. How old were you when you attempted suicide?
5. When was the last time you attempted suicide?
6. Describe to me how you healed from attempting suicide?
7. What helped you heal?
8. What was helpful about it?
9. What did those aspects mean to you?
10. How did you know when you were healed?
11. Thinking back to when you were suicidal, what would you have done differently?
12. If there were a message you could send to First Nations youth about attempting suicide, what would it be?
13. Is there anything else that you think I should know?
14. How are you feeling now after doing the interview?
APPENDIX B

RECRUITMENT POSTING
APPENDIX C

LETTER OF INITIAL CONTACT
APPENDIX D

PARTICIPANT INFORMED CONSENT FORM
APPENDIX E

RESOURCE LIST
RESOURCE LIST

Vancouver

SAFER – Suicide Attempt Counselling Services:
604-879-9251

Vancouver Crisis Line:
604-872-3377 (24 hours)

Indian Residential School Survivors Society Crisis Line:
1-866-925-4419 (24 hours)

Port Alberni

Kuu-us Crisis Society Crisis Line:
250-723-4050

Crisis Prevention, Intervention and Information Centre for Northern B.C.:
Crisis line: 1-888-562-1214
Youth line: 1-250-564-8336 or 1-888-564-8336

Indian Residential School Survivors Society Crisis Line:
1-866-925-4419 (24 hours)

Nanaimo

Central Vancouver Island Crisis Society:
250-754-4447

Crisis Prevention, Intervention and Information Centre for Northern B.C.:
Crisis line: 1-888-562-1214
Youth line: 1-250-564-8336 or 1-888-564-8336

Indian Residential School Survivors Society Crisis Line:
1-866-925-4411 (24 hours)